Group Life and Accidental Death Claim Forms for Employee or Dependent



To the Employer

The loss of a valued employee, or their loved one, can be difficult and we want to assist you in filing the claim as quickly as possible. Please read all instructions below regarding completion of these forms.

 All claims must be submitted, along with the beneficiary designation form(s) on file with the Employer/Plan, if any. If none on file, the Policyholder/Employer shall certify to that fact on the claim form.

Submit claim by mail to: The Hartford

Group Life Claims

P.O. Box 14299 Lexington, KY 40512-4299 By Fax to: 1-866-954-2621

By E-Mail to: gbclaimcslife@thehartford.com

PART I - EMPLOYER'S STATEMENT - TO BE COMPLETED IN FULL FOR ALL CLAIMS (1 of 2)

(Please verify if the employee qualifies for any other group benefits through The Hartford and submit the claim accordingly)

Policy Number(s):	Lifo/AD2D:	AD&D:	Business Travel Accident:		9-7,
, ,		AD&D	Busiliess Travel Accident.		
	er/Employer Name:			10 : 10 : (1)	
Name of Insured/I	=mployee:			Social Security N	umber:
Employee's Full A	ddress:			Date of Birth:	Date of Death:
If you already ha	ve a copy of the death ce	rtificate, please su	bmit it with the claim applicat	ion.	
Insured/Employee	s's Marital Status (if known):	Married Dive	orced Single Widowed	Partnered U	Inknown
Date of Hire:	Effective date of employee Insurance:	e's Salaried Hourly	Branch/Location: C	occupation:	
Classification: Cla	ss (if known):		Full-time Part-time	Union	
Employee's actual date last physically 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):					
Premiums paid to	date for Insured/Employee	?: Yes No If	No, date insurance was discont	inued or not in force	e:
Indicate if any of the following apply to this Employee: Has been approved for LBO/Accelerated Death Benefits Has been Approved for Waiver of Premium Applied for Conversion Applied for Portability					
AMOUNT OF INSURANCE BEING CLAIMED FOR EMPLOYEE OR AMOUNT IN FORCE FOR EMPLOYEE IF DEPENDENT CLAIM					
 Form is to be completed in its entirety and signed by the Official Representative of the Policyholder/Employer on page 2. Submission of claims on any voluntary or contributory Life plans, including Dependent coverage, must include copies of paper enrollment forms and/or online enrollment screen prints of current and two prior plan years for history of benefit elections and timely enrollment. AD&D Amount(s) should only be included if death was due to an accident. 					
Basic Life: \$			Supplemental Life: \$		
AD&D Basic: \$			AD&D Supplemental: \$		
_	to calculate Benefit Amo of Earnings used to calculat		gs should be as defined in your p	eekly Monthly	
Regular number o	f hours scheduled to work	Effective date earnings:	· · · · · · · · · · · · · · · · · · ·	rnings include commes?: Yes No	
If Supplemental Li Annual Enrollmen Date elected:	fe coverage is in force, was t?: Yes No	this elected during	Did employee complete Evide Yes No Date EOI approved:	ence of Insurability (EOI)?
Does the coverage claimed above reflect age reductions?:					

Please continue on next page

The Hartford Financial Services Group, Inc., (NYSE: HIG) operates through its subsidiaries, including underwriting companies Hartford Life and Accident Insurance Company and Hartford Fire Insurance Company, under the brand name, The Hartford®, and is headquartered at One Hartford Plaza, Hartford, CT 06155. For additional details, please read The Hartford's legal notice at www.thehartford.com. The Hartford is the administrator for certain group benefits business written by Aetna Life Insurance Company and Talcott Resolution Life Insurance Company (formerly known as Hartford Life Insurance Company). The Hartford also provides administrative and claim services for employer leave of absence programs and self-funded disability benefit plans.

Group Life and Accidental Death Claim Forms for Employee or Dependent



PART I - EMPLOYER'S STATEMENT (2 OF 2)
BENEFICIARY / CONTACT INFORMATION - TO BE COMPLETED BY EMPLOYER/TPA FOR ALL CLAIMS

Do you have beneficiary designations on file? Yes No If Yes, please include all designations with your claim submission • Please provide beneficiary contact information below, if available. Otherwise, provide known contact information for next of kin or insured's emergency contact				
Has the beneficiary completed a Funeral Home As If Yes, please include the Funeral Assignment If No, please provide any Funeral Home information.	nt with your claimsub	mission	☐ No	
Name of Insured/Employee:			ial Security No.:	
Beneficiary Name:	Date of Bir		ationship:	
Full Mailing address:	Date of bil	iii.	auonamp.	
Telephone Number: () Cell Number:	() F-m	ail Address:		
Beneficiary Name:	Date of Bir		ationship:	
Full Mailing address:	2 3.5 5. 2			
Telephone Number: () Cell Number:	() E-m	ail Address:		
Beneficiary Name:	Date of Bir		ationship:	
Full Mailing address:			•	
Telephone Number: () Cell Number:	E-m	ail Address:		
DEDENDENT INCOM	IATION ONLY COMP	_ETE_FOR DEPENDEN	T CLAIM	
If dependent claim is for a child, provide necessary				
dependent child was incapacitated, as applicable	e. Our claim team can h	elp you if you're unsure v	what paperwork is necessary.	
Full name of Deceased Dependent	Deceased Social S	ecurity Date of Birth D	Date of Death Relationship to Employee	
Last Residence (number, street, City, State, Zip Code)	Number Is Employee Actively	vet Work? Vee No	Have premiums been paid to date for	
	If No, complete date la	ast worked and reason on pa	ge 1 this dependent? Yes No	
	endent child a full-time stu by the Policy, include sch		es, Was dependent child incapacitated? ☐ Yes ☐ No	
AMOUNT OF INS	SURANCE BEING CLA	IMED FOR DEPENDEN	ІТ	
 Submission of claims on any voluntary or contributory Life plans, including Dependent coverage, must include copies of paper enrollment forms and/or online enrollment screen prints of current and two prior plan years for history of benefit elections and timely enrollment 				
Include AD&D amount(s) only if death was due to	o an accident			
Basic Life: \$ Supplemental Life: \$ AD&D Basic: \$ AD&D Supplemental: \$				
If Supplemental Dependent Life coverage is in force, was Annual Enrollment?: Yes No Date elected:		Dependent?: Yes	te Evidence of Insurability (EOI) for No Date EOI Completed:	
Dependent benefit is a: Flat Amount Percental If a percentage, please complete amount of employee	insurance above	nt Does Coverage claim Yes No	ed reflect age reduction(s)?	
Indicate if any of the following apply to this Employee Has been approved for LBO/Accelerated Death B		n Approved for Waiver of	Dramium	
Has been Approved for Long Term Disability		• • •	pplied for Portability	
Thas been Applied for Long Term Disability Applied for Conversion Applied for Portability				
TRAVEL INFORMATION – ON			CCIDENT CLAIMS	
If available, please include any travel itineraries	s, incident reports or p	olice reports		
		Injury sustained during:	Work Activity Pleasure Activity	
Amount of BTA Insurance claimed: \$	Date of Accident:	Time of Accident	,	
Place of Accident: incident/police reports as available; attach separate sheet, if	- •	mstances of the Accident	and nature of Injuries, if known: (Include	
incluent/police reports as available, attach separate sheet, in				
EMPLOYER CERTIFICATION				
I hereby certify that the information provided on the E I agree that this information is subject to audit by The			g to the records of the Employer.	
Employer	Address			
Signature	 Date	Their Authorized	d Representative (Please print)	
			()	
Telephone Number E-mail Address			Facsimile Number	

Group Life and Accidental Death Claim Forms for EMPLOYEE or Dependent



PART II - BENEFICIARY'S STATEMENT

GROUP POLICYHOLDER/EMPLOYER NAME:

By signing below:

X

- Release of claim forms is not an admission of coverage; or that a claim is payable.
- · The Company reserves the right to require or to obtain further proof of information, if necessary, upon claim review.
- Please verify if employee may have qualified, was enrolled and covered, for any other group benefits through The Hartford and submit a claim accordingly. If uncertain, please contact the group policyholder/employer for assistance.

Name of Insured/Employee:		Date of Birth:	Social Security Number:
Deceased's Marital Status: Married	Divorced Single Widowed Pa	rtnered	
If known, please indicate the manner of de	eath below:		
Natural Accident Homicide Si	uicide Pending/Undetermined/Unknown	Cause (if known):	
Please provide a copy of the death cert		, ,	as soon as possible.
If the death was due to an accident, ple	ease note there is an additional question	onnaire to complete o	n page 4.
	DEATH BENEFIT PAYMENT		
	DEATH BENEFIT PAYMENT		
We will issue the full amount of		e to you by chec	k, provided we have
	the insurance proceeds payab	le to you by chec	k, provided we have
We will issue the full amount of received all necessary documen	the insurance proceeds payab	e to you by chec	k, provided we have
received all necessary docume	the insurance proceeds payable		
	the insurance proceeds payable		k, provided we have
received all necessary docume	the insurance proceeds payable ntation.		Relationship:
received all necessary documents Beneficiary Name: (print)	the insurance proceeds payable ntation. Date of the U.S. resident Non-reside	of Birth:	Relationship: V-8BEN)
Beneficiary Name: (print) Citizenship: U.S. citizen Complete Mailing Address: (Number & St	the insurance proceeds payable ntation. Date (U.S. resident Non-resident Estate)	of Birth: ent alien (Request a Viciary's Social Security of Trust Tax ID:	Relationship: V-8BEN)
Beneficiary Name: (print) Citizenship: U.S. citizen	the insurance proceeds payable ntation. Date (U.S. resident Non-resident Estate)	of Birth: ent alien (Request a Viciary's Social Security	Relationship: V-8BEN)
Beneficiary Name: (print) Citizenship: U.S. citizen Complete Mailing Address: (Number & St	the insurance proceeds payable ntation. Date (U.S. resident Non-resident Estate)	of Birth: ent alien (Request a Viciary's Social Security of Trust Tax ID:	Relationship: V-8BEN)
Reneficiary Name: (print) Citizenship: U.S. citizen Complete Mailing Address: (Number & St (City, State & Zip Code)	the insurance proceeds payable ntation. Date of the insurance proceeds payable ntation. Date of the insurance proceeds payable ntation. Date of the insurance proceeds payable ntation.	of Birth: ent alien (Request a Viciary's Social Security e /Trust Tax ID: I address:	Relationship: V-8BEN) Number or

(1) I Hereby Certify and Agree that I have read and understand the IMPORTANT NOTICE page within this claim form.

(3) I Understand and Agree that if I receive claim proceeds which are not due to me, I will reimburse The Hartford.

Signature (4)

(2) I Hereby Certify that the information provided on this Beneficiary Statement is true and complete, to the best of my knowledge.

Group Life and/or Accidental Death Claim Form for EMPLOYEE or DEPENDENT



Claimant's Statement of Accidental Death (complete only if death was due to an accident)

If death was due to an accident, death certificate must be submitted at time of claim

• If you do not know or have a response to a question, please indicate "Unknown" If a question does not apply, please indicate "N/A" **Group Policyholder/Employer Name:** Group Policy Number(s): Life/AD&D: AD&D: **Business Travel Accident:** Name of Insured/Employee: **Social Security Number:** Name of Deceased: (if different from above) Age: Relationship to Employee: Spouse Child Has a Workers' Compensation claim been filed? Yes If "Yes," what is the status of the claim? Where did the accident happen? City: State: On what date did the accident happen? Please describe injuries received: Did accident result in death? Yes No If "Yes," on what date? If injury was sustained while traveling on policyholder/employer business, please complete the following: Scheduled Trip End Date: _ Trip Begin Date: _ Injury was sustained during: Work Activity Pleasure Activity For all accident claims, please complete the following: Describe in detail how the accident happened: Name and address of law enforcement agency involved: (Please submit copy of Police Accident Report and/or Case Number) List name/address/phone number of all physicians consulted for the injury/death: List name/address/phone number of all hospitals consulted: Did the deceased have any chronic disease or physical defect or deformity? Yes No If "Yes", describe in detail: Was an autopsy performed? No If "Yes," provide name/address/telephone number of coroner, if known: Yes Was an inquest held? Yes No If "Yes", verdict:

Please complete and sign the Authorization to Obtain and Disclose Information on page 6

Important Notice - 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, Alabama, California, Colorado, Florida, Kentucky, Maine, Maryland, New Jersey, New York, Ohio, Oklahoma, 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 Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

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 information to obtain or amend insurance coverage or to make a 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 Ohio: Any person who, with intent to defraud or knowing he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

For residents of Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

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.

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.

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.

LC-7371-21	Page 5 of 6	12/2022		
	Signature	Date		
The statements contained in the	nis form are true and complete to the best of my knowledge ar	nd belief.		
be subject to a civil penalty no	be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.			





I allow all doctors, hospitals, other health care providers, pharmacy, pharmacy benefit managers, government agencies (including, but not limited to, Federal, State or Local, and the Social Security Administration and Veterans Administration), insurers, employers, financial institutions, educational institutions, health plans, health insurance carriers, policyholders, contract holders, vendors, health and benefit insurers and administrators or their successors ("Records Holders") to give to and discuss with The Hartford and its representatives, the following personal, private, or privileged information, records, or documents related to:			
		XXX-XX-	
Language Manager (Diagram Debat)	Data at Diate		
Insured's Name (Please Print)	Date of Birth	Last 4 Digits of Social Secu	inty Number
Any and all medical information or records, inclupharmaceutical records, and treatment notes, ar alcohol or substance abuse, and behavioral or ninsurance coverage and claims filed, including a academic transcripts. The information obtained I subsidiaries and affiliates) for the purpose of evaluation of th	nd including information nental health (but exclossible) Il records and informa by use of this Authoriz aluating and administe	n regarding HIV/AIDS, commoduding psychotherapy notes); in tion related to such coverage ation will be used by The Hart	unicable diseases, nformation on any and claims; and tford (including
I understand that once My Information has been re-disclosed by The Hartford as permitted by law Hartford to use or disclose My Information (i) to relating to benefits; b) responding to any litigation resolution, or lawful subpoena (including regarding plan; or (d) claim, other audits or benefit program and wellness vendors, of my employer's benefit program related functions or data aggregation and vendors used for claims administration or process plan/program or claim; (iv) to any health care propersons or entities performing business, medical, reinsurance or analytical purposes, including wor subrogation or reimbursement purposes; (vii) as the personal safety of others or myself; (ix) as maccomplaints; and (x) as may be reasonably necess Information disclosed to The Hartford and re-discussions and the substance abuse, HIV/AIDS, other communicables.	or my further authoriziny employer for: a) rest, agency or regulatory or employment claims; reviews; (ii) to adminitude analysis; (iii) to any of analysis; (iii) to any of essional who has treat, or legal services related the employment of the em	ation. Without limiting the foregoonding to complaints by me of proceeding, grievance, alternation; c) fulfilling fiduciary obligation strators or other service provides, including leave management electronic claim systems or provide to the control of the contr	going, I authorize The or my representative ative dispute as under my benefit ers, including health at, for plan, benefit, or ograms or third party related to my benefit ay do so; (v) to other surance, illity insurance, or necessary to protect or similar derstand that My alcohol and
I understand that once My Information is given of may be re-disclosed by The Hartford. I also undersubject to re-disclosure by the recipient. The Autor upon my written revocation, if earlier, except a fraud, adjudicate a benefits claim, respond to record myself. I understand that a revocation of this Holders or The Hartford has relied on this Authorical for benefits or to contest the policy. If I do claim and determine whether I am eligible for better the Information released under this Authorization.	erstand that information thorizations set forth has may be reasonably gulatory or similar con Authorization is not efinization or to the extent of sign this Authorization or the symmetries. This may resulted the content of the extent of the	on disclosed pursuant to this A terein expire two years from the necessary to prevent or detemplaints, or protect the person fective to the extent that any out that the Hartford has a legal tion, The Hartford may not be tin a delay or denial of my recommend.	Authorization may be ne date listed below, ct perpetration of a al safety of others of my Record I right to contest a e able to review my quest for benefits.
The Information released under this Authorization can be submitted to The Hartford electronically, by phone or fax, or by mail. I agree that a copy of this Authorization may be treated as a signed original. I understand that I am entitled to receive a copy of this Authorization upon request. 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 Claimant or Legal Representati	ve Date	Name and Relation	onship to Claimant I Representative)

Form must be signed and dated

The Hartford Financial Services Group, Inc., (NYSE: HIG) operates through its subsidiaries, including underwriting companies Hartford Life and Accident Insurance Company and Hartford Fire Insurance Company, under the brand name, The Hartford®, and is headquartered at One Hartford Plaza, Hartford, CT 06155. For additional details, please read The Hartford's legal notice at www.thehartford.com. The Hartford is the administrator for certain group benefits business written by Aetna Life Insurance Company and Talcott Resolution Life Insurance Company (formerly known as Hartford Life Insurance Company). The Hartford also provides administrative and claim services for employer leave of absence programs and self-funded disability benefit plans.