THE HARTFORD

PROOF OF LOSS – ACCIDENTAL DEATH
HARTFORD FIRE INSURANCE COMPANY
HARTFORD LIFE INSURANCE COMPANY
HARTFORD LIFE AND ACCIDENT ISURANCE COMPANY

Name of Policyholder			Policy Number
Name of Insured	Address		Social Security Number
Class	Occupation	Date Last Worked	Principal Sum

Rate of Base Earnings Exclude overtime, commissions, bonuses, etc.
☐ Hourly ☐ Weekly ☐ Monthly ☐ Annually

Date Employed	Date Insurance Effective	Dependent's Effective Date	Termination Date (if applicable)

If insurance is terminated, please explain reason:

Was injury sustained in connection with any employment? ☐ Yes ☐ No If Yes, please explain

Mail benefit check to ☐ Employer or ☐ Beneficiary with copy to Administrator/Employer

I hereby certify that the information provided is true and complete according to the records of the Policyholder. I agree that this information is subject to audit by The Hartford and/or it's representatives.

_____ _____ _____
Date Signature of authorized representative Title

_____ _____
Address Phone

STATEMENT OF BENEFICIARY

Name of Beneficiary	Address	Age	Social Security Number

Fully describe the accident (include what, when, where and how it occurred). Use a separate sheet of paper if necessary.

To: Any physician, medical practitioner, hospital, clinic or other medical or medically related facility or provider of medical or dental services or supplies, and any employer, group policyholder, or contract holder or insurer.

I authorize you to release to The Hartford or it's representatives any and all information you may have about the mental and physical history, condition and treatment, and the wages and insurance coverage of _____(deceased).

I understand the information obtained by use of the Authorization will be used for the purpose of evaluating and administering a claim for benefits. Any information obtained will not be released by The Hartford to any person or organization EXCEPT to reinsuring companies, Medical Information Bureau, Inc. group policyholder, or other persons or organizations performing business or legal services in connection with my claim, or as may be otherwise lawfully required or as I may further authorize. For the purpose of disclosing information, I understand that this authorization is valid for a period of one year.

I know that I may request to receive a copy of this authorization.

If this authorization is given in connection with a claim for health benefits, disability or life insurance benefits, I understand that it is valid for the duration of the claim. A photocopy of this authorization shall be as valid as the originals

_____ _____ _____ _____
Signature of Beneficiary Beneficiary Telephone Number Relationship to Deceased Date:

Beneficiary must read and sign Page 2 of this form

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

For residents of all states **EXCEPT:** Arkansas, California, Colorado, Florida, New Jersey, New Mexico, Pennsylvania and Virginia: 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 substantial civil penalty where and to the extent allowed by state law.

For residents of Arkansas, New Jersey 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 insurance policy 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 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 Colorado: It is unlawful to knowingly provide false, 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 settlement or award shall be reported to the Colorado Division of Insurance.

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 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 thereto commits a fraudulent insurance act, which is a crime and subjects a person to criminal and civil penalties.

_____ _____

Signature Date

Mail the completed claim form along with the Insured Person's enrollment forms, beneficiary designation (and all changes thereto), certified copy of death certificate (photocopies are unacceptable) and newspaper articles concerning the accident to: The Hartford, ATTN: Group Life Claims, P.O. Box 2999, Hartford, CT 06104-2999.