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Clear Form

HARTFORD LIFE INSURANCE COMPANY
HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
STATEMENT OF CLAIM FOR LIVING BENEFITS/ACCELERATION OF DEATH BENEFITS

THE HARTFORD

STATEMENT OF EMPLOYER/POLICY HOLDER

Full Name of Employee: *(Last, first, middle initial)*	Employee Social Security No.:	Last Residence: (*No. Street, City or Town, State, Zip Code)*	
Employer: CBIA Service Coroporation	Branch or Subsidiary:	Date of Birth:	Date Employed:
Policy Number: 677347/703586	Effective Date of Employee's Insurance:	Date Last Actively at Work:	Date First Disabled:	Classification
Reason employee did not return to work after last day worked:	Have premiums been paid to date for this insured? ☐ Yes ☐ No		Occupation:

AMOUNT OF INSURANCE

Basic Life: $ _____ Supplemental Life: $ _____

Benefit based on previous year's W-2? ☐ Yes ☐ No

Amount of Living Benefit requested*: $ _____

*Note: The amount being requested may not exceed the percentage of the Employee/Insured's Life Insurance Amount set forth in the policy, and is subject to the minimum and maximum amounts contained in the policy. Accelerated benefits may be taxable and may affect eligibility for public assistance. **We recommend that you contact your Tax Advisor with any questions.**

(Complete only if amount of insurance is based on earnings schedule.)

Rate of basic earnings on date last worked: $ _____

☐ Hourly ☐ Weekly ☐ Monthly ☐ Annually

Was an application for conversion completed? ☐ Yes ☐ No

Was a claim for Long Term Disability or Waiver of Premium submitted to Hartford Life prior to date of death? ☐ Yes ☐ No

Has claimant assigned any portion of this Life Insurance to another party or parties? ☐ Yes ☐ No (If "Yes," attach copy of Assignment, along with a fully completed Consent Form for Payment of Living Benefit Option/Accelerated Death Benefits.)

Mail benefit check to: ☐ Employer ☐ Employee with copy to Employer

Employer Address: *(No., Street, City or Town, State, Zip Code)*

PLEASE SEE REVERSE SIDE OF FORM FOR EMPLOYER CERTIFICATION

STATEMENT OF INSURED EMPLOYEE OR MEMBER

Full Name of Insured: *(Employee/Member)*	Address of Insured: *(Employee/Member)*	Date of Birth:

Name and Address of Policyholder: *(Employer, Union)*

Nature of Illness or Injury Causing Present Disability:

On what date were you first totally disabled so that you were wholly unable to work? _____

Are you now wholly unable to work? ☐ Yes ☐ No

Have you applied for a Conversion Life policy from Hartford Life? ☐ Yes ☐ No

Names and addresses of Physicians who have treated you during Present Disability

Name of Physician:	**Address:** ***(No., Street, City or Town, State/Zip Code)***	**Treatment Dates From:** _____ **To:** _____
Name of Physician:	**Address:** ***(No., Street, City or Town, State/Zip Code)***	**Treatment Dates From:** _____ **To:** _____
Name of Physician:	**Address:** ***(No., Street, City or Town, State/Zip Code)***	**Treatment Dates From:** _____ **To:** _____

I hereby certify that the information provided by me in this Statement of Claim form is true and complete to the best of my knowledge and belief, and I have read and understand the statements on the reverse side. I hereby authorize any hospital or physician who has attended or examined me to disclose to Hartford Life or any of its representatives all information acquired by reason of, and records pertaining to, such hospitalization, examination and attendance. My consent is hereby granted to use this original or a photostatic copy as equally valid authorization.

Date: _____ Signature of Insured (Employee/Member): _____

Witness: _____

STATEMENT OF ATTENDING PHYSICIAN - GROUP LIFE INSURANCE 'LIVING BENEFITS'/ACCELERATED DEATH BENEFITS REQUEST

Your patient has requested an advanced payment of benefits on his/her group life insurance policy carried through Hartford Life. To qualify for this benefit, the patient must have a medical condition that, with reasonable medical certainty, will result in the death of the insured in less than (6) (12) (24) months from the date of this statement. Your assistance is requested to help us determine your patient's eligibility.

Name of Patient:	Date of Birth:	Social Security Number:

What is the disease causing this patient to be terminally ill? Please provide the diagnosis and subjective findings.

When did symptoms first appear?	Date patient was informed of diagnosis:	First treatment date:	Last treatment date:

Frequency of treatment: ☐ Daily ☐ Weekly ☐ Monthly ☐ Other _____

Has this ilness affected the mental capacity of the patient? ☐ Yes ☐ No
If "Yes," is the patient still capable of managing his own affairs? ☐ Yes ☐ No

Has the patient ever had the same or similar condition? ☐ Yes ☐ No
If "Yes," please state when and describe:

Will the patient's condition, with reasonable certainty, result in the patient's death within: ☐ 6 months ☐ 12 months ☐ 24 months

Name of Physician:	Degree:	Specialty:

Address of Physician:	Telephone Number:

Signature of Physician:	Date:

For residents of all states *EXCEPT* California, Florida, New Jersey, Colorado, Pennsylvania, Arkansas, New Mexico, 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 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.

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 Louisiana: 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 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 purposeof defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

EMPLOYER CERTIFICATION: ***I hereby certify that the information provided is true and complete according to the records of the Employer.*** *I agree that this information is subject to audit by Hartford Life Insurance Company or Hartford Life and Accident Insurance Company and/or its representative.* ***Note: Please make sure to forward to the Insured/Employee the Living Benefit Option/ Accelerated Death Benefit Disclosure form, along with this form.***

Dated _____ Address _____

_____ By _____
(Employer) *(Their Authorized Representative)* *(Please print)*

(_____) _____
(Telephone Number)