

# 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): Life/AD&D: _____ AD&D: _____ Business Travel Accident: _____		
Group Policyholder/Employer Name: _____		
Name of Insured/Employee: _____		Social Security Number: _____
Employee's Full Address: _____	Date of Birth: _____	Date of Death: _____

**If you already have a copy of the death certificate, please submit it with the claim application.**

Insured/Employee's Marital Status (if known): <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Partnered <input type="checkbox"/> Unknown				
Date of Hire: _____	Effective date of employee's Insurance: _____	<input type="checkbox"/> Salaried <input type="checkbox"/> Hourly	Branch/Location: _____	Occupation: _____
Classification: Class (if known): _____ <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Union				
Employee's actual date last physically at work: _____				
Provide reason employee did not return to work on their next scheduled workday: _____				
<input type="checkbox"/> Illness <input type="checkbox"/> FMLA (provide approval form) <input type="checkbox"/> Retirement - Date: _____ <input type="checkbox"/> Other (please explain): _____				
Premiums paid to date for Insured/Employee?: <input type="checkbox"/> Yes <input type="checkbox"/> No If No, date insurance was discontinued or not in force: _____				
Indicate if any of the following apply to this Employee:				
<input type="checkbox"/> Has been approved for LBO/Accelerated Death Benefits		<input type="checkbox"/> Has been Approved for Waiver of Premium		
<input type="checkbox"/> Has been Approved for Long Term Disability		<input type="checkbox"/> Applied for Conversion		<input type="checkbox"/> 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: \$ _____	
<b>Earnings, if used to calculate Benefit Amount (reported earnings should be as defined in your policy. Attach W-2 if applicable)</b>			
Employee's Rate of Earnings used to calculate benefit Amount: \$ _____ <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually <input type="checkbox"/> W-2			
Regular number of hours scheduled to work (if applicable): _____	Effective date of above reported earnings: _____	Do earnings include commissions or bonuses?: <input type="checkbox"/> Yes <input type="checkbox"/> No	
If Supplemental Life coverage is in force, was this elected during Annual Enrollment?: <input type="checkbox"/> Yes <input type="checkbox"/> No		Did employee complete Evidence of Insurability (EOI)?	
Date elected: _____		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		Date EOI approved: _____	
Does the coverage claimed above reflect age reductions?: <input type="checkbox"/> Yes <input type="checkbox"/> No			

**Please continue on next page**

The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries, including underwriting companies Hartford Life and Accident Insurance Company and Hartford Fire Insurance Company. Home Office is Hartford, CT. 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 Assignment, and provided it to you?  Yes  No

- If Yes, please include the Funeral Assignment with your claim submission
- If No, please provide any Funeral Home information available to you:

Name of Insured/Employee:		Social Security No.:
Beneficiary Name:	Date of Birth:	Relationship:
Full Mailing address:		
Telephone Number: ( )	Cell Number: ( )	E-mail Address:
Beneficiary Name:	Date of Birth:	Relationship:
Full Mailing address:		
Telephone Number: ( )	Cell Number: ( )	E-mail Address:
Beneficiary Name:	Date of Birth:	Relationship:
Full Mailing address:		
Telephone Number: ( )	Cell Number: ( )	E-mail Address:

### DEPENDENT INFORMATION - ONLY COMPLETE FOR DEPENDENT CLAIM

- If dependent claim is for a child, provide necessary paperwork to support the dependent was a full-time student OR support the dependent child was incapacitated, as applicable. Our claim team can help you if you're unsure what paperwork is necessary.

Full name of Deceased Dependent	Deceased Social Security Number	Date of Birth	Date of Death	Relationship to Employee
Last Residence (number, street, City, State, Zip Code)	Is Employee Actively at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, complete date last worked and reason on page 1		Have premiums been paid to date for this dependent? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Was the dependent child over the Policy's limiting age? <input type="checkbox"/> Yes <input type="checkbox"/> No	Was the dependent child a full-time student? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, and required by the Policy, include school enrollment verification		Was dependent child incapacitated? <input type="checkbox"/> Yes <input type="checkbox"/> No	

### AMOUNT OF INSURANCE BEING CLAIMED FOR DEPENDENT

- 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 an accident

Basic Life: \$	Supplemental Life: \$	AD&D Basic: \$	AD&D Supplemental: \$
If Supplemental Dependent Life coverage is in force, was this elected during Annual Enrollment?: <input type="checkbox"/> Yes <input type="checkbox"/> No Date elected:		Did employee complete Evidence of Insurability (EOI) for Dependent?: <input type="checkbox"/> Yes <input type="checkbox"/> No Date EOI Completed:	
Dependent benefit is a: <input type="checkbox"/> Flat Amount <input type="checkbox"/> Percentage of Employee's amount If a percentage, please complete amount of employee insurance above		Does Coverage claimed reflect age reduction(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Indicate if any of the following apply to this Employee:			
<input type="checkbox"/> Has been approved for LBO/Accelerated Death Benefits	<input type="checkbox"/> Has been Approved for Waiver of Premium		
<input type="checkbox"/> Has been Approved for Long Term Disability	<input type="checkbox"/> Applied for Conversion	<input type="checkbox"/> Applied for Portability	

### TRAVEL INFORMATION – ONLY COMPLETE FOR BUSINESS TRAVEL ACCIDENT CLAIMS

- If available, please include any travel itineraries, incident reports or police reports

Trip Begin Date: \_\_\_\_\_ Scheduled Trip End Date: \_\_\_\_\_ Injury sustained during:  Work Activity  Pleasure Activity

Amount of BTA Insurance claimed: \$ \_\_\_\_\_ Date of Accident: \_\_\_\_\_ Time of Accident (hr, min) \_\_\_\_\_: \_\_\_\_\_  AM  PM

Place of Accident: \_\_\_\_\_ Fully describe the circumstances of the Accident and nature of Injuries, if known: (Include incident/police reports as available; attach separate sheet, if necessary)

### EMPLOYER CERTIFICATION

I hereby certify that the information provided on the Employer Statement is true and complete, according to the records of the Employer. I agree that this information is subject to audit by The Hartford and/or its representative.

Employer	Address		
Signature	Date	Their Authorized Representative (Please print)	
( )		( )	
Telephone Number	E-mail Address	Facsimile Number	

# Group Life and Accidental Death Claim Forms for EMPLOYEE or Dependent



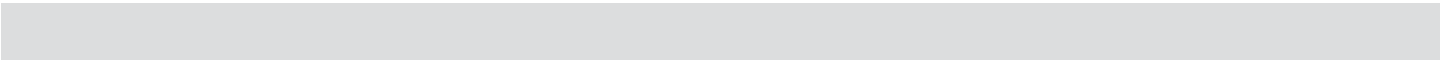
## PART II - BENEFICIARY'S STATEMENT (1 of 2)

**Release of claim forms is not an admission of coverage under a policy for an employer, group or organization**

We know this is a difficult time, and we want to assist you in filing your claim as quickly as possible. Please read all instructions below regarding completion of these forms. Also, please read the "Important Notice" on page 6.

- This form is to be completed in its entirety indicating your current address, date of birth and Social Security Number.
- **If the claim proceeds are payable to an Estate**, the beneficiary section below must be completed by the Executor or Administrator of the Estate. An official certificate of such person's legal appointment and qualification must be attached to this form. Please include the Estate Tax Identification Number. If none available, please explain.
- **If the claim proceeds are payable to a Trust**, the beneficiary section below must be completed by the Trustee and/or Successor Trustee(s) of the Trust. Applicable Trust pages indicating the name and date of the Trust; name of Trustee and Successor Trustee; and signature pages, must be attached to this form. Please include the Trust Tax Identification Number. If none available, please explain.
- **If any designated beneficiary is a minor**, the beneficiary section below must be completed by a custodian or guardian. Include the minor's Social Security Number and copy of the minor's birth certificate. Letters of Guardianship/Conservatorship and the supporting Court Order appointing the guardian/conservator for the minor's **estate or property** must also be included, if applicable.
- **If the claim is for a dependent child enrolled in an accredited school of higher learning**, submitted documents should include a student enrollment form executed by the school, applicable if required under the Policy.
- **If the claim submitted is for a Foreign Death**, Include both the Official Death Certificate and the Death of American Citizen abroad form. Please note that additional documents may be required upon claim review.

The Company reserves the right to require or to obtain further proof of information should it be deemed necessary.



Name of Deceased:	Date of Death:	Claim Number (if known):
Deceased's Permanent Address:		
Deceased's Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Partnered		
If the death certificate has been made available to you, please mark the manner of death: <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Homicide <input type="checkbox"/> Suicide <input type="checkbox"/> Pending/Undetermined/Unknown Cause (if known): _____		
<b>Please provide a copy of the death certificate with your submission. If not available, please submit as soon as possible. If the death was due to an accident, please note there is an additional questionnaire to complete on page 5.</b>		
Please provide the Funeral Home information:		
Name: _____	Contact Person: _____	Telephone Number: _____ (     )

***Please continue on next page to elect a payment option***

# Group Life and Accidental Death Claim Forms for EMPLOYEE or Dependent



## PART II - BENEFICIARY'S STATEMENT (2 of 2)

GROUP POLICYHOLDER/EMPLOYER NAME: _____		
Name of Insured/Employee:	Date of Birth:	Social Security Number:

### Substitute W-9 Statement

<p><b>Under penalties of perjury, I certify that:</b></p> <p>(1) the number shown on this form is my correct taxpayer identification; and</p> <p>(2) I am not subject to a back-up withholding, because, (a) I am exempt from back-up withholding; or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest and dividends; or (c) the IRS has notified me that I am no longer subject to back-up withholding; and</p> <p>(3) I am a U.S. person (including a U.S. resident alien).</p> <p><b>Certification Instructions:</b> You must cross out item (2) above, if you have been notified by the IRS that you are currently subject to back-up withholding, because, you have failed to report all interest and dividends on your tax return.</p>	
<p><b>The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.</b></p>	
Signature:	Date:

### DEATH BENEFIT PAYMENT

**We will issue the full amount of the insurance proceeds payable to you by check, provided we have received all necessary documentation.**

Beneficiary Name: (print)	Date of Birth:	Relationship:
Citizenship: <input type="checkbox"/> U.S. citizen <input type="checkbox"/> U.S. resident <input type="checkbox"/> Non-resident alien (Request a W-8BEN)		
Complete Mailing Address: (Number & Street)	Beneficiary's Social Security Number or Estate /Trust Tax ID:	
(City, State & Zip Code)	Telephone Number: Day: (    )    Evening: (    )	
Personal Cell Telephone Number: (    )    May we have your authorization to leave confidential medical and benefit information on your personal cell phone? <input type="checkbox"/> Yes <input type="checkbox"/> No and/or request this by e-mail? <input type="checkbox"/> Yes <input type="checkbox"/> No Please initial here: _____ to confirm your election		
<b>By signing below:</b>		
(1) <b>I Hereby Certify and Agree</b> that I have read and understand the IMPORTANT NOTICE on page 6 of this claim form package.		
(2) <b>I Understand and Agree</b> that payment of the claim proceeds according to any alternate mode of settlement specified in the policy will only be made if the Company receives a written request for such alternate method of payment from me prior to the payment of the claim proceeds.		
(3) <b>I Hereby Certify</b> that the information provided on this Beneficiary Statement is true and complete, to the best of my knowledge.		
(4) <b>I Understand and Agree that if I receive claim proceeds which are not due to me, I will reimburse The Hartford.</b>		
Signature: <b>X</b>	Date:	E-mail address:

**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 "N/A"
- You must complete and sign the Authorization to Obtain and Disclose Information found on pages 7 and 8

**Group Policyholder/Employer Name:** \_\_\_\_\_

**Group Policy Number(s):** Life/AD&D: \_\_\_\_\_ AD&D: \_\_\_\_\_ Business Travel Accident: \_\_\_\_\_

<b>Name of Insured/Employee:</b>	<b>Social Security Number:</b>
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Name of Deceased: (if different from above)	Age:	Relationship to Employee: <input type="checkbox"/> Spouse <input type="checkbox"/> Child
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Has a Workers' Compensation claim been filed?  Yes  No If "Yes," what is the status of the claim? \_\_\_\_\_

On what date did the accident happen? \_\_\_\_\_ Where did the accident happen? City: \_\_\_\_\_ State: \_\_\_\_\_

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:

Trip Begin Date: \_\_\_\_\_ Scheduled Trip End 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?  Yes  No If "Yes," provide name/address/telephone number of coroner, if known: \_\_\_\_\_

Was an inquest held?  Yes  No If "Yes", verdict: \_\_\_\_\_

**Please complete and sign the Authorization to Obtain and Disclose Information, pages 7 and 8**

**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 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.

The statements contained in this form are true and complete to the best of my knowledge and belief.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

# AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION



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:

Insured's Name (Please Print)

Date of Birth

Employer/Policyholder's Name:

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 substance abuse, and behavioral or mental health (but excluding psychotherapy notes); 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 or other government 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(s) and/or request(s) for accommodation. Such information shall be referred to herein collectively as "My Information."

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. Without limiting the foregoing, 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, adverse or discriminatory treatment related to my claim or condition; c) responding to complaints by me or my representative relating to benefits, leave or accommodation; d) responding to any litigation, agency or regulatory proceeding, grievance, alternative dispute resolution, 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, other audits or benefit program reviews; (ii) to administrators 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/program 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, reinsurance or analytical 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 or myself; (ix) as may be reasonably necessary to respond to regulatory or similar complaints; and (x) as may be reasonably necessary to prevent or detect perpetration of a fraud. I understand that My Information disclosed to The Hartford and re-disclosed to others could include information regarding alcohol and substance abuse, HIV/AIDS, other communicable diseases, and behavioral and mental health records.

***(Continue to next page)***

I understand that once my Information is given out as allowed in this form, federal privacy laws may not protect it and it may be re-disclosed by The Hartford. I also understand that information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient. The Authorizations set forth herein expire two years from the date listed below, or upon my written revocation, if earlier, except as may be reasonably necessary to prevent or detect perpetration of a fraud, adjudicate a benefits claim, respond to regulatory or similar complaints, or protect the personal safety of others or myself. I understand that if The Hartford is the administrator of my employer's self-insured disability program or leave program that my employer is entitled to receive my records without this Authorization. I understand that a revocation of this Authorization is not effective to the extent that any of my Record Holders or The Hartford has relied on this Authorization or to the extent that the Hartford has a legal right to contest a claim for benefits or to contest the policy. If I do not sign this Authorization, The Hartford may not be able to review my claim and determine whether I am eligible for benefits. This may result in a delay or denial of my request 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.

**NOTICE TO INFORMATION PROVIDERS:**

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family members genetic tests, the fact that an individual or an individuals' family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. Please note that it is appropriate under GINA to provide family medical history when an employee is requesting leave to care for a family member.

\_\_\_\_\_  
**Signature of Claimant or Legal Representative**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Name and Relationship to Claimant** *(if signed by Legal Representative)*

**Form must be signed and dated.**