

**How to File a Medical or Disability Claim  
For Business Travel Accident (ETB) Policies**



Attached is a Notice of Claim (Claim Form) for your Business Travel Accident policy.  
Please forward claims and questions to the following address:

Hartford Life Claims  
P.O. Box 3856  
Alpharetta, GA 30023  
Toll Free Number: (800) 678-6702  
Fax Number: (866) 954-3993

**Step 1- Submit a completed Notice of Claim (claim form) to our office either by fax or mail**

**The Policyholder (Not Claimant or Agent) should:**

- Fully answer each item in the Policyholder Certification section and sign the Policyholder Certification statement at the bottom of this section.
- Read and sign the Fraud Warning Certification statement located on the reverse side of the Notice of Claim.

**The Claimant should:**

- Fully answer each question in the Claimant Certification section and sign the Claimant Certification statement at the bottom of this section.
- Read and sign the Fraud Warning Certification statement located on the reverse side of the Notice of Claim.
- The Policyholder and Claimant must sign/date the Fraud Warning Certification statement at the bottom of Section III (reverse side of the Notice of Claim) indicating they have read the Fraud Warning information

**Step 2- Submit itemized medical bills for payment consideration to our office. If the policy is Excess, also include any other insurance carrier's corresponding Explanation of Benefits (EOBs)**

*Helpful information for submitting claims and expediting payment*

- A complete Notice of Claim is required for each accident/injury a Claimant incurs.
- A complete Notice of Claim must be submitted even if an ACCORD form is being provided. Required for each accident/injury a Claimant incurs.
- Providers may wish to bill us directly for their services. If they do, please ensure a Notice of Claim has first been submitted to our office.
- Itemized medical bills (including claimant name, date of service, diagnosis, procedure codes, amount charged, and provider information) should be submitted for processing. "Balance Due" statements and/or incomplete bills do not provide enough claim detail to process the charges. In order to ensure we receive complete claim information, we suggest providers submit standardized billing statements (called "UB-04" for hospital charges and/or a "CMS-1500" for physician charges).
- Unless proof of payment is submitted with the medical bill (a copy of check, a medical bill that indicates the claimant has made all or partial payment or zero balance information) claim payment is generally sent directly to the medical providers.

Please detach this page and forward the completed Notice of Claim (and medical bills if you are submitting expenses for payment) to the address listed above. We recommend you keep copies of the correspondence you are submitting to use for future reference.



**CLAIMANT CERTIFICATION-** To be completed by Claimant

If you are filing a claim for Accident Medical Expense (AME) benefits, please advise if you have medical coverage through:

- Your Employer?\*
- Spouses Employer?\*
- Medicare policy?
- Medicaid policy?
- Any other medical policy?\*

\* If yes, please provide details: \_\_\_\_\_

\* If yes and this policy is Excess, please include any other insurance carrier's Explanation of Benefits (EOBs) for each medical bill submitted. Note, your employer will be able to advise if this policy was written on an Excess basis.

If you are filing a claim for Accident Total Disability (ATD) benefits, please provide the following:

Attending physician's name:	Telephone Number: (    )
Attending physician's address:	Fax number: (    )

**Claimant Certification Signature Required:**

I certify the above information to be true and accurate to the best of my knowledge. I further certify I have read and signed the Fraud Warning statement listed at the bottom of this form. I also authorize any physician/hospital that has attended me to disclose any information thus acquired for the purposes of this claim payment.

\_\_\_\_\_  
Claimant's Signature

\_\_\_\_\_  
Date

**FRAUD WARNING CERTIFICATION - To be signed by Policyholder and Claimant (Based on State of residence)**

For residents of Alaska, Arizona, Arkansas, Colorado, Connecticut, Delaware, D.C., Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico North Carolina, North Dakota, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Washington, West Virginia and Wisconsin: 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 such person to criminal and civil penalties.

For residents of Alabama, Hawaii, Oregon, Vermont, Virginia, and Wyoming: 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 is subject to a denial and/or reduction insurance benefits and may be subject to any civil penalties available.

For residents of California, California law requires the following: 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 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.

I hereby certify the foregoing statements made by me on this form to be true to the best of my knowledge. I am aware that if any of the foregoing statements on this form made by me are willfully false, I may be subject to penalties, which may include criminal prosecution.

\_\_\_\_\_  
Signature of Policyholder Official

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian or Adult Claimant

\_\_\_\_\_  
Date