

**HARTFORD FIRE INSURANCE COMPANY  
HARTFORD LIFE INSURANCE COMPANY  
HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY**



**NOTICE OF CLAIM - FOR VOLUNTEER FIREFIGHTER ACCIDENT MEDICAL AND DISABILITY BENEFITS**

A claim is being filed for:  Medical Benefits  Disability Benefits  Medical and Disability Benefits

Medical Benefits: Forward Questions/Claims to: P.O. Box 3856, Alpharetta, GA 30023  
Phone Number: (800) 678-6702 Fax Number(866) 954-3993

Disability Benefits: Forward Questions/Claims to: P.O. Box 2999, Hartford, CT 06101-5302  
Phone Number: (888) 232-5340 Fax Number: (866) 913-4044

Claim Instructions: The Policyholder should: Complete and sign Sections I and III  
The Claimant should: Complete Sections II, III and IV and V-A  
The Attending Physician should: Complete and sign Section V-B

**Section I - Policyholder Information - To be completed by Fire Commanding Officer**

Policyholder Name		Policyholder Number
Policyholder Address		Commanding Officers Phone Number ( )
Claimant (Injured Party) Name	Claimant Date of Birth	Claimant Social Security Number
Claimant Insured Person Status <input type="checkbox"/> Volunteer <input type="checkbox"/> Junior Fire Fighter <input type="checkbox"/> Fire Fighter Auxiliary		
Claimant Address (Street, City, State and Zip Code)		Claimant Phone Number ( )
Date of Accident mm/dd/yyyy	Time of Accident hh:mm <input type="checkbox"/> AM <input type="checkbox"/> PM	Place of Accident
Complete description of Accident		
Indicate injured body part(s)		
Nature of Sickness (if applicable)		Date Sickness first commenced
Note - Please also include a copy of the Incident Report (if available)		
<i>Policyholder Certification Signature Required:</i> I hereby certify the Claimant is a member of the group insured under the above Policy and the injury/sickness was sustained under adequate supervision while participating in an official Covered Activity.		
Title of Commanding Officer	Signature of Commanding Officer	Date

**Section II - Claimant Information - To be completed by Claimant**

- If filing a claim for Medical Benefits:* Submit itemized medical bills to address referenced above and sign the Claimant Certification statement listed below.

*Claimant Certification Signature Required:*

I hereby certify the above information to be true and accurate to the best of my knowledge.

Signature of Claimant \_\_\_\_\_ Date \_\_\_\_\_

Normal Occupation	Normal Occupation Work Hours	Name of Normal Occupation Employer	
Address of Normal Occupation Employer		Contact Phone Number ( )	Contact Fax Number ( )

**Section II - (Continued) Claimant Information**

Contact Name for Normal Occupation Employer	Exact duties unable to perform - Normal Occupation
Date last worked Normal Occupation Employer	Date returned to work - Normal Occupation Employer <input type="checkbox"/> Full Duty <input type="checkbox"/> Light Duty
Verification of Earnings (Submit Normal Occupation pay stubs for the last 3 months. If self-employed, send copy of your prior years tax return).	
Attending Physician's Name	Attending Physician's Address
Attending Physician's Phone Number (    )	Attending Physician's Fax Number (    )
Do you have <u>disability</u> (loss of wages) coverage through? (Check all that apply) <input type="checkbox"/> Regular Occupation Policy <input type="checkbox"/> Worker's Compensation <input type="checkbox"/> Other	
<i>Claimant Certification Signature Required:</i> I hereby certify the above information to be true and accurate to the best of my knowledge.	
Signature of Claimant	Date

**Section III - Fraud Warning Statement - 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, Ohio, 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

**Section IV - AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION**



To: Any health care provider, employer, benefit plan, insurer, financial institution, consumer reporting agency, educational institution, or Federal, State, or Local Government Agency, including the Social Security Administration and Veterans Administration. I authorize you to disclose to The Hartford<sup>1</sup> a complete copy of any and all of the following personal or privileged information, records or documents relative to:

\_\_\_\_\_  
Insured's Name (*Please print*)

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Last 5 Digits of Social Security Number

Any and all medical information or records, including x-ray films, medical histories, physical, mental or diagnostic examinations, and treatment notes, and including information regarding HIV/AIDS, communicable diseases, alcohol or drug abuse, and mental health, as such information may be related to my claim for benefits; work information and history, including job duties, earnings and personnel records, and client lists; information on any insurance coverage and claims filed, including all records and information related to such coverage and claims; credit information, including credit reports and credit applications; other financial information, including pension benefits, bank records; business transactions billing, invoices, and payment records; academic transcripts; and information concerning Social Security 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 for the purpose of evaluating and administering my claim for benefits under my employer's benefit plan. Such information shall be referred to herein collectively as "My Information." I understand I have the right to revoke this Authorization for future disclosures, except to the extent action has been taken in reliance upon this Authorization. I must revoke this Authorization in writing directly to The Hartford.

**I ALSO 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. I authorize The Hartford to use or disclose My Information (i) to my employer for; a) functions related to accommodating my disability; b) responding to claims related to accommodation or adverse or discriminatory treatment related to my claim; c) responding to any litigation or agency charge document production request or lawful subpoena; d) federal or state Family & Medical Leave Act administration; e) matters relating to its workers' compensation arrangements; or f) fulfilling fiduciary obligations under my benefit plan; (ii) to the administrator or other service providers of my employer's benefit plan or other benefit plans of my employer for plan-related functions; (iii) to any claim system used for claims processing or insurance broker to carry out functions related to my benefit plan 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 or legal services related my claim; vi) to my employer's workers' compensation insurance carrier or administrator; (vii) as may be lawfully required; or (viii) as may be necessary to prevent or detect perpetration of a fraud.

I understand that information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient. I understand that I have the right to revoke this Authorization for future disclosures The Hartford may make unless The Hartford has taken action in reliance upon this Authorization. I must revoke this Authorization in writing directly to The Hartford. I understand that my medical treatment or payment for medical benefits cannot be conditioned on my allowing The Hartford to re-disclose My Information. The authorizations set forth herein expire two years from the date listed below, or upon my revocation, if earlier, but will not exceed the term of my coverage under the policy or benefit plan, except as may be necessary to prevent or detect perpetration of a fraud. I understand that I am entitled to receive a copy of this Authorization upon request. A photocopy or facsimile of this Authorization shall be as valid as the original. 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 Insured or Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Insured (*if signed by Guardian*)

<sup>1</sup> The Hartford® is The Hartford Financial Services Group, Inc., and its subsidiaries, including issuing companies Hartford Fire Insurance Company, Hartford Life Insurance Company, Hartford Life and Accident Insurance Company, and its administrative services company Hartford-Comprehensive Employee Benefit Service Company, and any of their parents, affiliates, subsidiaries and/or third-party contractors. Also as used herein, The Hartford provides insurance or claim administration services to my employer's employee welfare benefit plan(s).

**Section V - Attending Physician's Statement for Medical and Disability Services**  
**(The patient is responsible for the completion of this form without expense to Company)**

**To be completed by the Claimant**

Name of patient	Social Security Number:	Date of Birth
Address of patient (Street, City, State or Province & Zip Code or Postal Code)		
Name of policyholder	Policy Number	
I hereby authorize release of information on this form by the below named physician for the purpose of claim processing.		
Signed (Patient)		Date

Claimant Name	Social Security Number	Date of Birth
Diagnosis and Concurrent Conditions (ICD-9 code) (If fracture or dislocation, describe nature and location.)		
Is treatment due to <input type="checkbox"/> Sickness <input type="checkbox"/> Accident		
When did symptoms first appear or accident happen? Date _____		
When did patient first consult you for this condition? Date _____		
Has patient ever had same or similar condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," state when and describe. Date _____		
Nature of surgical procedure, if any, (describe fully) performed CPT Code. _____		
Is patient still under your care for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No Date _____		
Did you refer patient to another physician? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If "Yes", Name, address, telephone number. _____ _____ _____		

How long was or will patient be continuously unable to work at <b>Normal Occupation*?</b>		From _____ Thru _____
How long was or will patient be able to perform some but not all duties of his <b>Normal Occupation*?</b>		From _____ Thru _____
*LIMITATION (If there is a limitation, check	<input type="checkbox"/> Standing	<input type="checkbox"/> Climbing
	<input type="checkbox"/> Bending	<input type="checkbox"/> Use of Hands
<input type="checkbox"/> Walking	<input type="checkbox"/> Stopping	<input type="checkbox"/> Lifting
<input type="checkbox"/> Psychological	<input type="checkbox"/> Other (State which) _____	
To your knowledge does patient have other health Insurance or health plan coverages? If "Yes", identify. <input type="checkbox"/> Yes <input type="checkbox"/> No		

Attending Physician's Name (Please print or type.)		Telephone Number ( )
License Number		Fax Number ( )
Street address (Street, City, State & Zip Code)		
SS# or E.I.N.#	Degree	Specialty
Signature _____		Date Signed _____