GROUP VOLUNTARY ACCIDENT INSURANCE BENEFIT HIGHLIGHTS

More than 3.5 million children ages 14 and younger get hurt annually playing sports or participating in recreational activities.[1]

FRIENDSWOOD INDEPENDENT SCHOOL DISTRICT

With Accident insurance, you'll receive payment(s) associated with a covered injury and related services. You can use the payment in any way you choose – from expenses not covered by your major medical plan to day-to-day costs of living such as the mortgage or your utility bills.

To learn more about Accident insurance, visit **thehartford.com/employeebenefits**

COVERAGE INFORMATION

You have a choice of three accident plans, which allows you the flexibility to enroll for the coverage that best meets your needs. This insurance provides benefits when injuries, medical treatment and/or services occur as the result of a covered accident. Unless otherwise noted, the benefit amounts payable under each plan are the same for you and your dependent(s).

PLAN INFORMATION		PLAN 2	PLAN 3
Coverage Type		On and off-job (24 hour)	On and off-job (24 hour)
BENEFITS			
EMERGENCY, HOSPITAL & TREATMENT CARE		**PLAN 2**	**PLAN 3**
Accident Follow-Up	Up to 3 visits per accident	$25	$50
Acupuncture/Chiropractic Care/PT	Up to 10 visits each per accident	$25	$50
Ambulance – Air	Once per accident	$750	$1,000
Ambulance – Ground	Once per accident	$200	$300
Blood/Plasma/Platelets	Once per accident	$200	$400
Child Care	Up to 30 days per accident while insured is confined	$25	$30
CHIROPRACTIC CARE	Up to 10 visits each per accident	$15	$30
Daily Hospital Confinement	Up to 365 days per lifetime	$150	$200
Daily ICU Confinement	Up to 30 days per accident	$200	$400
Diagnostic Exam	Once per accident	$100	$200
Emergency Dental	Once per accident	Up to $100	Up to $200
Emergency Room	Once per accident	$50	$200
Hospital Admission	Once per accident	$625	$1,250
Initial Physician Office Visit	Once per accident	$75	$100
Lodging	Up to 30 nights per lifetime	$100	$200
Medical Appliance	Once per accident	$100	$150
Rehabilitation Facility	Up to 15 days per lifetime	$50	$100
Transportation	Up to 3 trips per accident	$250	$500
Urgent Care	Once per accident	$50	$150
X-ray	Once per accident	$50	$75
SPECIFIED INJURY & SURGERY		**PLAN 2**	**PLAN 3**
Abdominal/Thoracic Surgery	Once per accident	$1,500	$2,000
Arthroscopic Surgery	Once per accident	$300	$400
Burn	Once per accident	Up to $5,000	Up to $10,000
Burn – Skin Graft	Once per accident for third degree burn(s)	25% of burn benefit	25% of burn benefit
Concussion	Up to 3 per year	$200	$400

Dislocation	Once per joint per lifetime	Up to $4,000	Up to $8,000
Eye Injury	Once per accident	Up to $400	Up to $600
Fracture	Once per bone per accident	Up to $6,000	Up to $9,000
Hernia Repair	Once per accident	$150	$200
Joint Replacement	Once per accident	$2,000	$3,000
Knee Cartilage	Once per accident	Up to $750	Up to $1,000
Laceration	Once per accident	$200	$400
Ruptured Disc	Once per accident	$750	$1,000
Tendon/Ligament/Rotator Cuff	Once per accident	Up to $1,000	Up to $1,500
CATASTROPHIC		**PLAN 2**	**PLAN 3**
Accidental Death	Within 90 days; Spouse @ 50% and child @ 25%	$25,000	$50,000
Common Carrier Death	Within 90 days	3 times death benefit	3 times death benefit
Coma	Once per accident	$5,000	$10,000
Dismemberment	Once per accident	Up to $30,000	Up to $50,000
Home Health Care	Up to 30 days per accident	$50	$50
Paralysis	Once per accident	Up to $5,000	Up to $10,000
Prosthesis	Up to 2 per accident	Up to $1,500	Up to $2,000
FEATURES		**PLAN 2**	**PLAN 3**
Ability Assist® EAP[2] – 24/7/365 access to help for financial, legal or emotional issues		Included	Included
HealthChampion[SM3] – Administrative & clinical support following serious illness or injury		Included	Included

PREMIUMS

The amounts shown are MONTHLY amounts (12 payments/deductions per year):[4]

COVERAGE TIER	PLAN 2	PLAN 3
Employee Only	**$9.10** ($0.30 per day)	**$15.68** ($0.52 per day)
Employee & Spouse	**$14.28** ($0.47 per day)	**$24.57** ($0.81 per day)
Employee & Child(ren)	**$14.92** ($0.49 per day)	**$25.78** ($0.85 per day)
Employee & Family	**$23.54** ($0.77 per day)	**$40.62** ($1.34 per day)

ASKED & ANSWERED

WHO IS ELIGIBLE?

You are eligible for this insurance if you are an active full-time employee who works at least 20 hours per week on a regularly scheduled basis and are less than age 80.

Your spouse and child(ren) are also eligible for coverage. Any child(ren) must be under age 25.

AM I GUARANTEED COVERAGE?

This insurance is guaranteed issue coverage – it is available without having to provide information about your or your family's health. All you have to do is elect the coverage to become insured.

HOW MUCH DOES IT COST AND HOW DO I PAY FOR THIS INSURANCE?

Premiums are provided above. You have a choice of plan options. You may elect insurance for you only, or for you and your dependent(s), by choosing the applicable coverage tier.

Premiums will be automatically paid through payroll deduction, as authorized by you during the enrollment process. This ensures you don't have to worry about writing a check or missing a payment.

WHEN CAN I ENROLL?

You may enroll during any scheduled enrollment period, within 31 days of the date you have a change in family status, or within 31 days of the completion of any eligibility waiting period established by your employer.

WHEN DOES THIS INSURANCE BEGIN?

The initial effective date of this coverage is September 1, 2018. Subject to any eligibility waiting period established by your employer, if you enroll for coverage prior to this date, insurance will become effective on this date. If you enroll for coverage after this date, insurance will become effective in accordance with the terms of the certificate (usually the first day of the month following the date you elect coverage).

You must be actively at work with your employer on the day your coverage takes effect. Your spouse and child(ren) must be performing normal activities and not be confined (at home or in a hospital/care facility).

WHEN DOES THIS INSURANCE END?

This insurance will end when you or your dependent(s) no longer satisfy the applicable eligibility conditions, or when you reach the age of 80, premium is unpaid, you are no longer actively working, you leave your employer, or the coverage is no longer offered.

CAN I KEEP THIS INSURANCE IF I LEAVE MY EMPLOYER OR AM NO LONGER A MEMBER OF THIS GROUP?

Yes, you can take this coverage with you. Coverage may be continued for you and your dependent(s) under a group portability policy. Your spouse may also continue insurance in certain circumstances.

[1]"Sports Injury Statistics." Stanford Children's Health, n.d. Web. 30 June 2017. http://www.stanfordchildrens.org/en/topic/default?id=sports-injury-statistics-90-P02787

[2]AbilityAssist® services are offered through The Hartford by ComPsych®. ComPsych is not affiliated with The Hartford and is not a provider of insurance services. The Hartford is not responsible and assumes no liability for the goods and services provided by ComPsych and reserves the right to discontinue any of these services at any time. Ability Assist is a registered trademark of The Hartford. Services may not be available in all states. Visit https://www.thehartford.com/employee-benefits/value-added-services for more information.

[3]HealthChampion℠ services are provided through The Hartford by ComPsych®. ComPsych is not affiliated with The Hartford and is not a provider of insurance services. The Hartford doesn't provide basic hospital, basic medical, or major medical insurance. HealthChampion specialists are only available during business hours. Inquiries outside of this timeframe can either request a call-back the next day or schedule an appointment. The Hartford is not responsible and assumes no liability for the goods and services provided by ComPsych and reserves the right to discontinue any of these services at any time. Health Champion is a service mark of ComPsych. Services may not be available in all states. Visit https://www.thehartford.com/employee-benefits/value-added-services for more information.

[4]Rates and/or benefits may be changed.

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The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries, including issuing companies Hartford Life Insurance Company and Hartford Life and Accident Insurance Company. Home Office is Hartford, CT. 5962g NS 08/16 © 2016 The Hartford Financial Services Group, Inc. All rights reserved.

This Benefit Highlights document explains the general purpose of the insurance described, but in no way changes or affects the policy as actually issued. In the event of a discrepancy between this document and the policy, the terms of the policy apply. **Benefits are subject to state availability. Policy terms and conditions vary by state.** Complete details including the provisions, terms, conditions, limitations and exclusions are in the Certificate of Insurance issued to each insured individual and the Master Policy as issued to the policyholder. The Hartford compensates both internal and external producers, as well as others, for the sale and service of our products. For additional information regarding Hartford's compensation practices, please review our website http://thehartford.com/group-benefits-producer-compensation. Accident Form Series includes GBD-2000, GBD-2300, or state equivalent

LIMITATIONS & EXCLUSIONS

This insurance coverage includes certain limitations and exclusions. The certificate details all provisions, limitations, and exclusions for this insurance coverage. A copy of the certificate can be obtained from your employer.

GROUP ACCIDENT INSURANCE

LIMITATIONS AND EXCLUSTIONS
The benefits payable are based on the insurance in effect on the date of the covered accident, subject to the definitions, limitations, exclusions and other provisions of the policy.

You and your dependent(s) must be citizens or legal residents of the United States, its territories and protectorates.

This insurance does not provide benefits for any loss that results from or is caused by:

- Suicide or attempted suicide, whether sane or insane, or intentionally self-inflicted injury
- War or act of war, whether declared or undeclared, or a nuclear, chemical, biological, or radiological event
- A covered person's participation in a felony, riot or insurrection
- A covered person's service in the armed forces or units auxiliary to it
- A covered person's taking drugs, unless as prescribed by or administered by a physician, or being intoxicated as defined by the jurisdiction in which the cause of loss was incurred
- While a covered person is on any aircraft: as a pilot, crewmember or student pilot; as a flight instructor or examiner; if it is owned, operated or leased by or on behalf of the policyholder, or any employer or organization whose eligible persons are covered under the policy; or being used for tests, experimental purposes, stunt flying, racing or endurance tests
- Operating, learning to operate, serving as a crew member of or jumping or falling from any aircraft
- Riding in or driving any motor-driven vehicle in a race, stunt show or speed test

All exclusions may not be applicable, or may be adjusted, as required by state regulations in the situs state of a group.

NOTICES

THIS IS A LIMITED ACCIDENT ONLY BENEFIT POLICY

This limited benefit plan (1) does not constitute major medical coverage, and (2) does not satisfy the individual mandate of the Affordable Care Act (ACA) because the coverage does not meet the requirements of minimum essential coverage.
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The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries, including issuing companies Hartford Life Insurance Company and Hartford Life and Accident Insurance Company. Home Office is Hartford, CT.

This Benefit Highlights document explains the general purpose of the insurance described, but in no way changes or affects the policy as actually issued. In the event of a discrepancy between this document and the policy, the terms of the policy apply. **Benefits are subject to state availability. Policy terms and conditions vary by state.** Complete details are in the Certificate of Insurance issued to each insured individual and the Master Policy as issued to the policyholder.

HOW TO SUBMIT A CLAIM FOR CRITICAL ILLNESS, ACCIDENT, AND/OR HOSPITAL INDEMNITY INSURANCE

Experiencing an illness, accident or hospital stay can be challenging. Now you need to file a claim, and the process may seem overwhelming. But The Hartford is here to make this as easy as possible.

<table>
<tr><th colspan="4">REFERENCE THE ACTION STEPS AND RESOURCES BELOW TO HELP YOU WITH YOUR CLAIM.</th></tr>
<tr><th>ACTION</th><th>CRITICAL ILLNESS</th><th>ACCIDENT</th><th>HOSPITAL INDEMNITY</th></tr>
<tr><td>When should a claim be filed?</td><td>• After a physician has diagnosed you or a covered dependent with a covered illness, or
• After you or your dependent has undergone a health screening and is eligible for a wellness or health screening benefit (if included in the policy).</td><td>After you or your covered dependents receive services performed as a result of an accident.</td><td>• After you or a covered dependent have had a hospital stay as the result of a covered illness or injury, or
• After you or a covered dependent receive services performed as a result of a covered illness or injury (if included in the policy), or
• After you or your dependent has undergone a health screening and is eligible for a wellness or health screening benefit (if included in the policy).</td></tr>
<tr><td>How and who can start a claim?</td><td colspan="3">You'll need to work directly with The Hartford to file your claim – this process is different from what you're used to with medical or dental insurance.
• Retrieve the form online at THEHARTFORD.COM/BENEFITS/MYCLAIM. Complete, sign and date this form electronically or in paper copy. For assistance in completing this form, contact (866) 547-4205.
• You'll only need to fill in the sections specific to the benefit for which you're filing a claim.
• If you are incapacitated and are unable to complete claim forms, then your authorized representative can file a claim on your behalf.</td></tr>
<tr><td>What information will you need to provide when submitting your claim?</td><td colspan="3">• The form will ask you to provide some information about you, and if you're filing the claim for a dependent, their information as well.
• Then select which type of claim you're filing – whether it's for Accident, Critical Illness and/or Hospital Indemnity insurance. Continue through the form, only filling out the relevant sections.
• In the Benefit Information section, check off each box that applies to the event or services you received as a result of your covered accident, illness or hospital stay.
In addition to filling out the form, you'll also need to provide supporting documentation to prove the claim – such as medical records, physician notes, hospital discharge papers, and itemized medical or hospital bills.
Please call us for guidance with your claim submission – we're happy to help you understand how to complete the claim successfully. By thoroughly filling out the form and gathering your documentation, we'll be able to better serve you and ensure your claim is processed efficiently.
You may also need to work with your physician to fully prove your claim, but we'll let you know during the claims process if this is necessary.</td></tr>
</table>

continued

ACTION	CRITICAL ILLNESS	ACCIDENT	HOSPITAL INDEMNITY
Where is a claim form sent?	Submit the completed form and supporting documentation through the online portal at **THEHARTFORD.COM/BENEFITS/MYCLAIM**. Or, you can mail or fax the form and documentation to: The Hartford Supplemental Insurance Benefit Department P.O. Box 99906 Grapevine, TX 76099 Fax Number: 1-469-417-1952		
What happens next?	After your claim is submitted, a dedicated Client Resolution Specialist will assess completeness of the claim and will contact you with any questions, or to request additional information needed for your claim. Our goal is to ensure you receive all benefits you are entitled to, as quickly as possible.		

For more information, please call **(866) 547-4205**, or visit **THEHARTFORD.COM/BENEFITS/MYCLAIM**.

From the online portal you'll be able to access and submit claims forms and manage claims status.

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The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries including issuing companies Hartford Life Insurance Company and Hartford Life and Accident Insurance Company. Home office is Hartford, CT. All benefits are subject to the terms and conditions of the policy. Policies underwritten by the issuing companies listed above detail exclusions, limitations, reduction of benefits and terms under which the policies may be continued in force or discontinued.

THE CRITICAL ILLNESS POLICY PROVIDES LIMITED BENEFITS FOR SPECIFIED DISEASES ONLY. This limited benefit plan (1) does not constitute major medical coverage, and (2) does not satisfy the individual mandate of the Affordable Care Act (ACA) because the coverage does not meet the requirements of minimum essential coverage. In New York: This policy provides limited benefits health insurance only. It does NOT provide basic hospital, basic medical or major medical insurance as defined by the New York State Department of Financial Services.

THIS IS A HOSPITAL CONFINEMENT INDEMNITY POLICY. THE POLICY PROVIDES LIMITED BENEFITS.

This limited benefit plan: (1) does not constitute major medical coverage, and (2) does not satisfy the individual mandate of the Affordable Care Act (ACA) because the coverage does not meet the requirements of minimum essential coverage.

Critical Illness Form Series includes GBD-2600, GBD-2700, or state equivalent.

Accident Form Series includes GBD-2000, GBD-2300, or state equivalent.

Hospital Income Plan Form Series includes GBD-2800, GBD-2900, or state equivalent.

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GROUP ACCIDENT, CRITICAL ILLNESS/SPECIFIED DISEASE & HOSPITAL INDEMNITY CLAIM FORM

Employee/Member/Claimant Statement

Hartford Life and Accident Insurance Company

In furnishing this form, The Hartford® does not waive any of its rights or defenses nor admit liability. The Hartford® is The Hartford Financial Services Group, Inc., and its subsidiaries.

Employee/Member/Claimant Responsibilities:

1) Complete, sign and date this form electronically or in paper copy. For assistance with completing this form, please call (866)547-4205.
2) To help prove the claim, provide all supporting documentation such as medical records, physician notes, ER/hospital discharge papers, radiology/pathology reports, itemized medical/hospital bills, medical EOBs, toxicology reports, child care/transportation/lodging receipts or police reports (if applicable following an accident). The claimant is responsible for any fees charged for proof requirements.
3) Submit the form and supporting documentation through the online portal at *thehartford.com/benefits/myclaim*. Alternatively, you may mail to The Hartford Supplemental Insurance Benefit Department, PO Box 99906, Grapevine, TX 76099; or fax to (469)417-1952.
4) If you are enrolled for any other group coverage through The Hartford for which benefits may be available as a result of the covered event, please submit the appropriate claim(s). Contact the employer/policyholder for assistance if you are uncertain of other coverage.

EMPLOYER/POLICYHOLDER INFORMATION

Employer/Policyholder Name	Policy Number

EMPLOYEE/MEMBER INFORMATION

Employee/Member Name (First MI Last)	SSN or Tax ID #	Gender ☐ Male ☐ Female
Address (Street, City, State & Zip)		Date of Birth
E-mail Address	Phone Number	Cell/Mobile Number

May we have your authorization to deliver confidential medical or benefit information via personal cell phone? ☐ Yes ☐ No
Via email? ☐ Yes ☐ No; If Yes to either personal cell phone or email, please initial here to confirm your response: __________

Does the employee/member have major medical insurance or other primary health insurance? ☐ Yes* ☐ No	*If Yes, provide name of insurance carrier and policy number:

Is the employee/member currently actively working?* ☐ Yes ☐ No; *If No, provide date last worked and reason:*	Hours Worked/Week*

*Complete these fields only if there is an employer/employee relationship between the employee/member and the group. Do not complete for other group types.

DEPENDENT INFORMATION – COMPLETE IF THIS CLAIM IS FOR A DEPENDENT OF THE EMPLOYEE/MEMBER

Dependent Name (First MI Last)	SSN or Tax ID #	Date of Birth	Relationship (To employee/member)

Is the dependent insured under Medicaid or any similar Title XIX program? ☐ Yes ☐ No	Is the child incapacitated/ disabled? (If applicable) ☐ Yes ☐ No	Is the child married or in a partnership? (If applicable) ☐ Yes ☐ No

Is the child a full-time student? (If applicable) ☐ Yes* ☐ No	*If Yes, provide name and contact info for the school:

CLAIM INFORMATION

Type of Claim (Check all that apply) ☐ Accident ☐ Critical Illness/Specified Disease ☐ Hospital Indemnity	Is this the first claim submitted for this event/insured? ☐ First Claim ☐ Additional/Follow-Up Claim

Nature of Illness/Injury/Diagnosis and/or Treatment Received* (For pregnancy, complete Pregnancy Information section below)

When did symptoms first appear or injury occur?* (For accidents, complete Accident Information section below)	Date First Diagnosed/Treated

Have you ever had this same or similar condition? ☐ No ☐ Yes; Explain what and when:*

*If additional space is needed, please provide on a separate sheet of paper and submit with this form. Include the employee/member name, SSN/Tax ID# and policy #.

PREGNANCY INFORMATION – COMPLETE IF THIS CLAIM IS THE RESULT OF A PREGNANCY

Date of Delivery/Expected Delivery Date	Type of Delivery/Expected Type of Delivery ☐ Vaginal ☐ Elective C-section ☐ Unplanned C-section	First Day of Last Period

Are/were there any complications of pregnancy? ☐ No ☐ Yes; Explain what and when:*

*If additional space is needed, please provide on a separate sheet of paper and submit with this form. Include the employee/member name, SSN/Tax ID# and policy #.

FORM CONTINUES ON NEXT PAGE

EMPLOYEE/MEMBER NAME_________________________________ EMPLOYEE/MEMBER SSN/TAX ID# ___________________ POLICY # ___________________

ACCIDENT INFORMATION – COMPLETE IF THIS CLAIM IS THE RESULT OF AN ACCIDENT

Date of Accident	**Time of Accident** (HH:MM) ☐ AM ☐ PM	**Who was involved in the accident?** (Check all that apply) ☐ Employee/Member ☐ Spouse ☐ Child(ren)
Location of Accident (Place Name, Street, City, State & Zip)		
Complete the rest of this section only if this claim is the first claim submitted for this injured person for this accident. Proceed to the Benefit Information section if this is an additional/follow-up claim.		
Was this a motor vehicle accident? ☐ Yes ☐ No	**Did any law agency investigate the accident?** ☐ Yes* ☐ No; *If Yes, provide a copy of report.*	***If Yes, provide agency name and contact info:**
Did the accident happen while the injured person was working? ☐ Yes** ☐ No		****If Yes, will/has a worker's comp (or equivalent) claim been filed?** ☐ Yes/To be Filed ☐ No
Provide a detailed explanation of the accident, including how it happened and what the injured person was doing at the time of the accident:***		

***If additional space is needed, please provide on a separate sheet of paper and submit with this form. Include the employee/member name, SSN/Tax ID# and policy #.

BENEFIT INFORMATION

Check each illness, injury, service or treatment for which a benefit is requested as a result of the event. If any previous claims have been submitted for this event, only check the benefits that are applicable to this new claim.

Benefits listed below may not be included in all certificates/policies. Refer to the certificate for available benefits, limitations and exclusions.

All relevant supporting documentation, such as medical records, physician notes, ER/hospital discharge papers, radiology/pathology reports, itemized medical bills (hospital, physician, ambulance, etc.), medical EOBs, toxicology reports or child care/ transportation/lodging receipts, should be included with this claim submission to help prove the claim. You can prevent the potential of a delay in processing the claim by providing complete and accurate information.

ACCIDENT

Emergency, Hospital & Treatment Care

☐ Physician Visit
☐ Urgent Care Visit
☐ Emergency Room
☐ Diagnostic Exam or X-Ray
☐ Ambulance
☐ Hospital Confinement
☐ Physical or Occupational Therapy
☐ Chiropractic Care or Acupuncture
☐ Rehabilitation Facility Confinement
☐ Transportation or Lodging
☐ Blood/Plasma/Platelets
☐ Emergency Dental – Crown/Extraction
☐ Accidental Ingestion of Controlled Drug
☐ Medical Appliance
☐ Child Care

Specified Injury & Surgery

☐ Concussion or Laceration
☐ Dislocation or Fracture
☐ Surgery
☐ Burns (Second or Third Degree)
☐ Eye Injury – Surgery or Object Removal
☐ Hernia Repair
☐ Joint Replacement

Catastrophic

☐ Death (Complete Death claim form)
☐ Coma
☐ Dismemberment or Paralysis
☐ Home Health Care
☐ Prosthesis

Other (Must be included in certificate/policy)

☐ ________________________________
☐ ________________________________
☐ ________________________________
☐ ________________________________
☐ ________________________________

HOSPITAL INDEMNITY

Confinement

☐ Hospital Confinement
☐ Continuous Care Confinement

Family Care

☐ Travel or Lodging
☐ Family Care
☐ Pet Care

Additional Care

☐ Ambulance
☐ Emergency Room
☐ Hospital Observation/Short Stay
☐ Diagnostic Exam, Lab Test or X-Ray
☐ Durable Medical Equipment
☐ Prescription Drug

Medical Professional Care

☐ Medical Professional/Physician Visit
☐ Urgent Care Visit
☐ Telemedicine Visit
☐ Therapy Services
☐ Home Health Services
☐ Durable Medical Equipment
☐ Prescription Drug

Other

☐ Inpatient Surgery
☐ Outpatient Surgery
☐ ________________________________
☐ ________________________________
☐ ________________________________

Riders

☐ AD&D (Complete Accident Catastrophic section to the left)
☐ Term Life (Complete Death claim form)
☐ Critical Illness (Complete Critical Illness section to the left)
☐ Short Term Care

CRITICAL ILLNESS/SPECIFIED DISEASE

Cancer

☐ Cancer (Invasive or Non-Invasive)
☐ Benign Brain Tumor
☐ Skin Cancer
☐ Second Opinion
☐ Prosthesis/Wig

Vascular

☐ Heart Attack (Myocardial Infarction)
☐ Stroke
☐ Coronary Artery Disease/Bypass
☐ Heart Transplant
☐ Aneurysm or Angioplasty/Stent

Other Illnesses

☐ Major Organ Transplant
☐ End Stage Renal (Kidney) Disease
☐ Coma or Paralysis
☐ Loss of Hearing, Speech or Vision
☐ Bone Marrow Transplant
☐ Occupational HIV/Hep

Neurological

☐ Advanced Parkinson's or Alzheimer's
☐ Amyotrophic Lateral Sclerosis (ALS)
☐ Advanced Multiple Sclerosis

Child

☐ Cerebral Palsy
☐ Congenital Heart Disease
☐ Cystic Fibrosis
☐ Muscular Dystrophy
☐ Spina Bifida

Other (Must be included in certificate/policy)

☐ Transportation or Lodging
☐ Physical Therapy or Home Health Care
☐ Rehabilitation Facility Confinement
☐ ________________________________
☐ ________________________________

FORM CONTINUES ON NEXT PAGE

PHYSICIAN INFORMATION* – INCLUDE ALL PHYSICIANS CONSULTED FOR CARE FOR THIS EVENT*

1/Physician Name		**2/Physician Name**		**3/Physician Name**	
Date(s) Treated	**Specialty**	**Date(s) Treated**	**Specialty**	**Date(s) Treated**	**Specialty**
Address (City, State & Zip)		**Address** (City, State & Zip)		**Address** (City, State & Zip)	
Phone #	**Fax #**	**Phone #**	**Fax #**	**Phone #**	**Fax #**

*If additional space is needed, please provide on a separate sheet of paper and submit with this form. Include the employee/member name, SSN/TAX ID# and policy number.

FACILITY INFORMATION – INCLUDE ANY URGENT CARE, ER OR HOSPITAL PROVIDING CARE FOR THIS EVENT*

1/Facility Name		**2/Facility Name**		**3/Facility Name**	
Date & Time Seen/Admitted ☐ AM ☐ PM		**Date & Time Seen/Admitted** ☐ AM ☐ PM		**Date & Time Seen/Admitted** ☐ AM ☐ PM	
Date & Time Discharged (If applicable) ☐ AM ☐ PM		**Date & Time Discharged** (If applicable) ☐ AM ☐ PM		**Date & Time Discharged** (If applicable) ☐ AM ☐ PM	
Address (City, State & Zip)		**Address** (City, State & Zip)		**Address** (City, State & Zip)	
Phone #	**Fax #**	**Phone #**	**Fax #**	**Phone #**	**Fax #**

*If additional space is needed, please provide on a separate sheet of paper and submit with this form. Include the employee/member name, SSN/TAX ID# and policy number.

CLAIMANT INFORMATION – COMPLETE ONLY IF THE CLAIMANT **IS NOT** THE EMPLOYEE/MEMBER

Claimant Name (First MI Last)	**Phone Number**	**Cell/Mobile Number**
Complete Mailing Address (Street/Box, City, State & Zip)	**E-mail Address**	

May we have your authorization to deliver confidential medical or benefit information via personal cell phone? ☐ Yes ☐ No
Via email? ☐ Yes ☐ No; If Yes to either personal cell phone or email, please initial here to confirm your response: _______________

CLAIMANT CERTIFICATION

By signing below, I hereby certify that:
1) The information provided on this form is true and complete to the best of my knowledge and belief; and
2) I have read and understand the "Important Notice–Fraud Warning Statements" that applies to my state of residence.

Claimant Signature	**Date of Signature**

GROUP ACCIDENT, CRITICAL ILLNESS/SPECIFIED DISEASE & HOSPITAL INDEMNITY CLAIM FORM

Authorization to Obtain and Disclose Information

Hartford Life and Accident Insurance Company

The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries, including insurance issuing company Hartford Life and Accident Insurance Company.

Employee/Member/Claimant Responsibilities:

1) A copy of this form must be submitted for each person for whom benefits are being claimed. This form is only required once per person per event, regardless of the number of claim submissions. For assistance, please call (866)547-4205.
2) Submit the form(s) to The Hartford Supplemental Insurance Benefit Department, PO Box 99906, Grapevine, TX 76099; or fax to (469)417-1952.

EMPLOYEE/MEMBER & POLICY INFORMATION

Employee/Member Name (First MI Last)	**Last 4 Digits of SSN or Tax ID #**	**Policy Number**

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

To any health care provider, employer, benefit plan, insurer, service provider, 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 a complete copy of any and all of the following personal or privileged information, records, or documents relative to:

Name of Insured Employee/Member or Dependent	**Date of Birth**	**Last 4 Digits of SSN or Tax ID #**

- 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;
- Work information and history, including job duties, earnings, personnel records, and client lists;
- Information on any insurance coverage and claims filed, including all records and information related to such coverage and claims; and
- Business transactions billing, invoice, and payment records;

The information obtained by use of this Authorization will be used for the purpose of evaluating and administering my claim for benefits and/or leave request. 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. I further 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 complaints by me or my representative relating to benefits or leave; d) responding to any litigation or agency document production request or lawful subpoena; e) federal, state, or other leave administration; f) fulfilling fiduciary obligations under my benefit plan; or (g) claim or other audits or reviews; (ii) to the administrator or other service providers of my employer ’s benefit plan, other benefits, and/or leave programs of my employer for plan, benefit, or program related functions or data aggregation and analysis; (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, medical, or legal services related to my claim; (vi) for other insurance or reinsurance purposes, including workers’ compensation insurance; (vii) as may be lawfully required; (viii) as may be reasonably necessary to protect the personal safety of others; or (ix) as may be reasonably 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 and no longer subject to the privacy protections under HIPAA. I understand that 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 understand that my medical treatment, payment, enrollment or eligibility for benefits cannot be conditioned on my signing this Authorization. I understand that this Authorization expires 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(ies) or benefit plan or program, except as may be reasonably necessary to prevent or detect perpetration of a fraud or protect the personal safety of others. 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/Claimant or Parent/Guardian (If insured is under 18)	**Date of Signature**	**Relationship to Insured**

GROUP ACCIDENT, CRITICAL ILLNESS/SPECIFIED DISEASE & HOSPITAL INDEMNITY CLAIM FORM

Important Notice – Fraud Warning Statements

Hartford Life and Accident Insurance Company

The Hartford® is The Hartford Financial Services Group, Inc., and its subsidiaries.

Please read the statement that applies to your state of residence prior to signing the claim form and prior to signing this form.

For residents of all states EXCEPT Arizona, California, Colorado, Florida, Kentucky, Maine, Maryland, New Jersey, New York, 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 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 or 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 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 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.

Signature	Date of Signature