STATEMENT OF CLAIM FOR HOSPITAL INCOME PLAN

THE HARTFORD

Clear Form

Certificate Number

INSURED MEMBER - FILL IN THIS PORTION COMPLETELY
INSURED'S STATEMENT
(IF SPACE IS NOT ADEQUATE IN ANY BLOCK, USE SEPARATE PAGE)

Insured's Social Security Number ___ — ___ — ____

Insured's Name:	Birthdate *(Mo Day YYYY.)*:	Gender: ☐ Male ☐ Female	Claim is for: ☐ Self ☐ Spouse ☐ Child
Insured's Address:			Email Address:

Phone Numbers Daytime: (____) _____ Evening: (____) _____ Personal Cell Telephone Number: (____) _____

May we have your authorization to leave confidential medical and benefit information on your personal cell phone? ☐ Yes ☐ No

and/or request this by e-mail: ☐ Yes ☐ No Please initial:_____ to confirm your election

Patient's Name	Birthdate *(Mo Day YYYY)*	Relationship	Marital Status ☐ Single ☐ Married

If patient is over age 18, but under age 27 and is attending school, show name and address of school.

Describe nature of injury or sickness requiring hospital confinement or outpatient surgery. If injury, how and where did it occur?

☐ Check here, if confinement due to cancer

Date injury, sickness or pregnancy began: _____ Date of first treatment for this condition: _____

Has the patient had the same or similar condition during the 12 months prior to confinement? ☐ Yes ☐ No If "Yes,"when?

Was this hospitalization due to an injury causing accident? ☐ Yes ☐ No

If you have a copy of the incident report, please provide a copy of that report.

If this document is completed by a Power of Attorney, please attach a copy of that document. In the event the insured is deceased, we will require a copy of the Certified Death Certificate.

We hereby authorize any physician, hospital, clinic, company or person having any records, data or other information concerning me or my dependents to furnish such records, data or information as may be requested by The Hartford or their duly authorized representative. A copy of this authorization shall be as valid as the original

Date _____ Insured Sign Here _____

Date _____ Patient Sign Here _____

PLEASE ATTACH COPY OF ITEMIZED HOSPITAL BILL, UB92 OR MEDICARE SUMMARY

Name and address of attending physician:

List all physicians consulted for care of this or similar condition during the 12 months prior to confinement:

NAME	ADDRESS	TELEPHONE NO.	PERIOD TREATED
			From ____ To ____
			From ____ To ____
			From ____ To ____
			From ____ To ____
			From ____ To ____

List all hospitals where confined for care of this or similar condition during the 12 months prior to confinement:

NAME	ADDRESS	TELEPHONE NO.	PERIOD CONFINED
			From ____ To ____
			From ____ To ____

Please return the completed claim form set to us, along with all of the required documentation. In addition, an Authorization to Release Medical Information form is included with this claim form which is to be used in the event we need to contact the Doctor(s) as shown above or on the Attending Physician's Statement.

ATTENDING PHYSICIAN'S STATEMENT * -- HEALTH INSURANCE CLAIM -- GROUP OR INDIVIDUAL

***Required only if claim date of service is within 12 months of insured's effective date of coverage.**

Patient's Name and Address | Age

Diagnosis and Concurrent Conditions **PLEASE INDICATE THE PRIMARY DX OR CAUSE FOR HOSPITALIZATION FIRST.**
(If Fracture or Dislocation, describe Nature and Location)

☐ **Check here if confinement due to cancer**

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? ☐ **Yes** ☐ **No**
(If "Yes," state when and describe.)

Nature of surgical procedure, if any.
(Describe fully)

CPT Code _____

Date performed _____

If performed in hospital, give name of hospital ☐ **Inpatient** ☐ **Outpatient**

Give dates of other medical (non-surgical) treatment, if any.

Office _____
Home _____
Hospital _____
Nursing Home _____

Is patient still under your care for this condition?
If "no," give date your services terminated. ☐ **Yes** ☐ **No** **Date** _____

To your knowledge, does patient have other health insurance or health plan coverage? If "Yes," identify. ☐ **Yes** ☐ **No**

Is condition due to injury or sickness arising out of patient's employment?
If "Yes," explain. ☐ **Yes** ☐ **No**

Has patient been treated for this illness/injury in the past 12 months? ☐ **Yes** ☐ **No**
If "Yes," give date(s) **Date(s) of Treatment** _____

Date | Signature (Attending Physician) | Degree | Telephone

Address (Street and Number, City or Town, State or Province, Zip Code)

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.

Signature - Please read the statement that applies to your state of residence and sign the bottom of the second 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.

Signature - Please read the statement that applies to your state of residence and sign the bottom of the page.

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

To be completed by Administrator of Insurance Plan - Not to be completed by Insured Member

Name of Insured Member _____ Paid to Date _____

Patient Name _____ Relationship _____

Name of Organization _____ Policy # _____ Cert # _____

Benefits: Member _____ Spouse _____ Child _____

Orig. Eff. Date: Member _____ Spouse _____ Child _____

Chge. Eff. Date: Member _____ Spouse _____ Child _____

Claim Date _____ Signed for Organization _____