

Send completed form to:
Plan Administrator
P. O. Box 9326
Des Moines, IA 50306

HARTFORD LIFE INSURANCE COMPANY
HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
STATEMENT OF CLAIM FOR SHORT TERM RECOVERY



INSURED'S STATEMENT

INSURED MEMBER - FILL IN THIS PORTION COMPLETELY

Certificate Number: _____

(IF SPACE IS NOT ADEQUATE IN ANY BLOCK, USE SEPARATE PAGE)

Primary Insured's Name	Birth date (Mo. Day Yr.)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
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Address: (Street, City, State & Zip Code)

Phone Numbers Home () Office ()	Claim is for <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Other
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Patient's Name if other than Primary	Birth date (Mo. Day Yr.)
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If claim is being filed for an eligible dependent, give dependent's insurance effective date.

Describe nature of injury or sickness requiring hospital confinement or outpatient surgery.

If injury, how and where did it occur?

Date injury or sickness began:	Date of first treatment for this condition:
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Name of attending physician: _____

Address of attending physician: _____

Has the patient had the same or similar condition during the 6 months prior to confinement? Yes No

If "Yes," when? _____

Please indicate the periods of hospital care/confinement for which benefits are being paid:

From _____ To _____ From _____ To _____ From _____ To _____

List all physicians consulted for care of this or similar condition during the 6 months prior to confinement, please include your primary care physician.

NAME	ADDRESS	PHONE NUMBER	PERIOD TREATED (mm/dd/yy)
_____	_____	()	From _____ To _____
_____	_____	()	From _____ To _____
_____	_____	()	From _____ To _____
_____	_____	()	From _____ To _____

List all hospitals/facilities where confined for care of this or similar condition during the 6 months prior to confinement:

NAME	ADDRESS	PHONE NUMBER	PERIOD CONFINED
_____	_____	()	From _____ To _____
_____	_____	()	From _____ To _____
_____	_____	()	From _____ To _____

Complete for claims of Recovery Benefit(s).

Dates for which Short Term Recovery Care as needed: _____

Please select Applicable Recovery Services Received:

- Skilled Nursing Care (provided by a registered Nurse (RN); Licensed Practical Nurse (LPN);
- Home Health Aide services;
- Homemaker services;
- Companion services;
- Speech, occupational or physical therapy,

Please provide supporting documentation for care received.

If 65 or over: (Medicare Summary Notice or Home Health Plan of Treatment).

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

For residents of all states EXCEPT Arkansas, California, Colorado, Florida, New Jersey, New Mexico, New York, Pennsylvania, Puerto Rico and Virginia: A person commits a fraudulent insurance act if that person knowingly, and with intent to defraud any insurance company or other person, either: (a) files an application for insurance or statement of claim containing any materially false information, or (b) conceals information concerning any material fact in order to obtain an insurance policy or a benefit under an insurance policy. **A fraudulent insurance act is a crime.** (In Oregon, a fraudulent insurance act may be a crime.) The Hartford shall pursue prosecution of any fraudulent insurance act to the fullest extent of the law.

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 Arkansas, New Jersey and New Mexico: 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 an insurance policy is subject to criminal and civil penalties.

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 thereto commits a fraudulent insurance act, which is a crime and subjects a person 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 A 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 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 its agent who knowingly provides false, incomplete, or misleading information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to an insurance settlement or award shall be reported to the Colorado Division of Insurance.

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 Puerto Rico: Any person who knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

For residents of Virginia: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Signature

Date

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.

By signing this document I attest to the accuracy of its content as well as confirm I have read and understand the above statement that may be applicable to my state, & if shown).

For the sake of obtaining information, I 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 HARTFORD LIFE INSURANCE COMPANY, HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY, or their duly authorized representative. A copy of this authorization shall be as valid as the original.

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

Please return the completed claim form set to us, along with all 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 *- SHORT TERM RECOVERY - GROUP

Required only if claim date of service is within 6 months of insured's effective date of coverage.

Patient's Name _____		Age _____
Address (Street, City, State & Zip Code) _____		
Diagnosis and Concurrent Conditions PLEASE INDICATE THE PRIMARY DX OR CAUSE FOR HOSPITALIZATION FIRST. (If Fracture or Dislocation, describe Nature and Location) _____		
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.) _____		
Nature of surgical procedure, if any. _____		
CPT Code _____	Date surgery performed _____	
Give dates of other medical (non-surgical) treatment, if any.		
Office _____	_____	_____
Home _____	_____	_____
Hospital _____	_____	_____
Nursing Home _____	_____	_____
Is patient still under your care for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If "no," give date your services terminated. _____		
Is condition due to injury or sickness arising out of patient's employment? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," explain. _____		
Has patient been treated for this illness/injury in the past 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," give date(s) _____		
Date(s) of Treatment _____		
If performed in hospital, give name of hospital. _____		
<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient		

Signature (Attending Physician) _____	Degree _____
Address (Street, City, State & Zip Code) _____	
Telephone Number () _____	Date _____

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 Hartford¹ 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 to 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 Relationship to Insured (*if signed by Guardian*) Date

¹ 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).