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 Claim Office
Blanket Lines Unit
One Hartford Plaza T-14
Hartford, CT 06155
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.equired 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.

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

Clear Form

Business Travel Accident (ETB) Notice of Claim

(For Accident Medical Expense & Accident Total Disability Benefits)

Hartford Life Claim Office
Blanket Lines Unit
One Hartford Plaza T-14
Hartford, CT 06155
Toll Free Phone Number (800) 678-6702
Fax Number: (866) 954-3993

POLICYHOLDER CERTIFICATION - To be completed by Policyholder Official

Policy Number:	Policyholder Name:	Policyholder Phone Number: ( )

Policyholder Address: (Street, City, State & Zip Code)

Agent Name:	Agent Phone Number: ( )

Claimant (Injured Party) Name:

Claimant Social Security Number:	Claimant Date of Birth:	Claimant Gender: ☐ Male ☐ Female	Claimant Phone Number: ( )

Claimant Address: (Street, City, State & Zip Code)

Date of Accident:	Time of Accident: ☐ AM ☐ PM	Place of Accident:

Cause of Accident:	Indicate injured body part(s):

Nature of Sickness (if applicable):	Date Sickness first commenced:

Claimant's Injury was due to:

☐ Business related accident, (Hazard C-12; 24 Hour Business Trip Coverage)
List reason for business trip and provide trip verification (i.e.Itinerary, Plane Ticket...) _____

☐ Pleasure related accident, (Hazard C-28; 24 Hour Business and Pleasure Coverage)

Claimant's Eligible Person "Class Number" (as defined by the Policy)

☐ Class 1 ☐ Class 2 ☐ Class 3 ☐ Other _____

At the time of the accident, what was the Claimant's employment status?

☐ Full-time ☐ Part-time ☐ Other _____

Claim is filed for:

☐ Accident Medical Expense (AME) benefits
If yes, please submit itemized medical bills (If the policy is Excess, please include any other insurance carrier's Explanation of Benefits (EOBs) for each medical bill submitted).

☐ Accident Total Disability (ATD) benefits
If yes, please provide Claimant's: Date last worked _____ Salary at time of accident: $_____
Current Employment Status: ☐ Full-time ☐ Part-time ☐ Other _____
Letter outlining Claimant's "duties of his or her regular occupation"

☐ Accident Death & Dismemberment (ADD) benefits
If yes, please forward claims/questions to our ADD department at our toll free number (888) 563-1124.

Policyholder Certification Signature Required:

I hereby certify this information to be true/accurate, the above claimant is a member of a group insured under the above policy number and the Claimant's injury was sustained as a direct result of the accident described above. I further certify I have **read and signed** the Fraud Warning statement listed on the reverse side of this form.

_____ _____ _____
Title of Policyholder Official | Signature of Policyholder Official | Date

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

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

With the exception of any source(s) of income reported above in this form, I certify by my signature that I have not received and am not eligible to receive any source of income, except for my disability benefits from this plan. Further, I understand that should I receive income of any kind or perform work of any kind during any period The Hartford has approved my disability claim, I must report all details to The Hartford, immediately. If I receive disability income benefits greater than those which should have been paid, I understand that I will be required to provide a lump sum repayment to the Plan. The Hartford has the option to reduce or eliminate future disability payments in order to recover any overpayment balance that is not reimbursed.

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 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 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.

The statements contained in this form are true and complete to the best of my knowledge and belief.

_____ _____

Signature Date