

# Group Life and Accidental Death Claim Forms for Employee or Dependent



**To the Employer**

The loss of a valued employee, or their loved one, can be difficult and we want to assist you in filing the claim as quickly as possible. Please read all instructions below regarding completion of these forms.

- All claims must be submitted, along with the beneficiary designation form(s) on file with the Employer/Plan, if any. If none on file, the Policyholder/Employer shall certify to that fact on the claim form.

**Submit claim by mail to: The Hartford  
Group Life Claims  
P.O. Box 14299  
Lexington, KY 40512-4299**

**By Fax to: 1-866-954-2621  
By E-Mail to: gbclaimcslife@thehartford.com**

**PART I - EMPLOYER'S STATEMENT - TO BE COMPLETED IN FULL FOR ALL CLAIMS (1 of 2)**

**(Please verify if the employee qualifies for any other group benefits through The Hartford and submit the claim accordingly)**

Policy Number(s): Life/AD&D: _____ AD&D: _____ Business Travel Accident: _____	
Group Policyholder/Employer Name: _____	
Name of Insured/Employee: _____	Social Security Number: _____
Employee's Full Address: _____	Date of Birth: _____ Date of Death: _____

**If you already have a copy of the death certificate, please submit it with the claim application.**

Insured/Employee's Marital Status (if known): <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Partnered <input type="checkbox"/> Unknown				
Date of Hire: _____	Effective date of employee's Insurance: _____	<input type="checkbox"/> Salaried <input type="checkbox"/> Hourly	Branch/Location: _____	Occupation: _____
Classification: Class (if known): _____ <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Union				
Employee's actual date last physically at work: _____				
Provide reason employee did not return to work on their next scheduled workday: _____				
<input type="checkbox"/> Illness <input type="checkbox"/> FMLA (provide approval form) <input type="checkbox"/> Retirement - Date: _____ <input type="checkbox"/> Other (please explain): _____				
Premiums paid to date for Insured/Employee?: <input type="checkbox"/> Yes <input type="checkbox"/> No If No, date insurance was discontinued or not in force: _____				
Indicate if any of the following apply to this Employee:				
<input type="checkbox"/> Has been approved for LBO/Accelerated Death Benefits		<input type="checkbox"/> Has been Approved for Waiver of Premium		
<input type="checkbox"/> Has been Approved for Long Term Disability		<input type="checkbox"/> Applied for Conversion <input type="checkbox"/> Applied for Portability		

**AMOUNT OF INSURANCE BEING CLAIMED FOR EMPLOYEE OR AMOUNT IN FORCE FOR EMPLOYEE IF DEPENDENT CLAIM**

- **Form is to be completed in its entirety and signed by the Official Representative of the Policyholder/Employer on page 2.**
- **Submission of claims on any voluntary or contributory Life plans, including Dependent coverage, must include copies of paper enrollment forms and/or online enrollment screen prints of current and two prior plan years for history of benefit elections and timely enrollment.**
- **AD&D Amount(s) should only be included if death was due to an accident.**

Basic Life: \$ _____	Supplemental Life: \$ _____
AD&D Basic: \$ _____	AD&D Supplemental: \$ _____
<b>Earnings, if used to calculate Benefit Amount (reported earnings should be as defined in your policy. Attach W-2 if applicable)</b>	
Employee's Rate of Earnings used to calculate benefit Amount: \$ _____ <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually <input type="checkbox"/> W-2	
Regular number of hours scheduled to work (if applicable): _____	Effective date of above reported earnings: _____
Do earnings include commissions or bonuses?: <input type="checkbox"/> Yes <input type="checkbox"/> No	
If Supplemental Life coverage is in force, was this elected during Annual Enrollment?: <input type="checkbox"/> Yes <input type="checkbox"/> No	Did employee complete Evidence of Insurability (EOI)? <input type="checkbox"/> Yes <input type="checkbox"/> No
Date elected: _____	Date EOI approved: _____
Does the coverage claimed above reflect age reductions?: <input type="checkbox"/> Yes <input type="checkbox"/> No	

**Please continue on next page**

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# Group Life and Accidental Death Claim Forms for Employee or Dependent



## PART I - EMPLOYER'S STATEMENT (2 OF 2)

### BENEFICIARY / CONTACT INFORMATION - TO BE COMPLETED BY EMPLOYER/TPA FOR ALL CLAIMS

Do you have beneficiary designations on file?  Yes  No If Yes, please include all designations with your claim submission

- Please provide beneficiary contact information below, if available. Otherwise, provide known contact information for next of kin or insured's emergency contact

Has the beneficiary completed a Funeral Home Assignment, and provided it to you?  Yes  No

- If Yes, please include the Funeral Assignment with your claim submission
- If No, please provide any Funeral Home information available to you:

Name of Insured/Employee:		Social Security No.:
Beneficiary Name:	Date of Birth:	Relationship:
Full Mailing address:		
Telephone Number: ( )	Cell Number: ( )	E-mail Address:
Beneficiary Name:	Date of Birth:	Relationship:
Full Mailing address:		
Telephone Number: ( )	Cell Number: ( )	E-mail Address:
Beneficiary Name:	Date of Birth:	Relationship:
Full Mailing address:		
Telephone Number: ( )	Cell Number: ( )	E-mail Address:

### DEPENDENT INFORMATION - ONLY COMPLETE FOR DEPENDENT CLAIM

- If dependent claim is for a child, provide necessary paperwork to support the dependent was a full-time student OR support the dependent child was incapacitated, as applicable. Our claim team can help you if you're unsure what paperwork is necessary.

Full name of Deceased Dependent	Deceased Social Security Number	Date of Birth	Date of Death	Relationship to Employee
Last Residence (number, street, City, State, Zip Code)	Is Employee Actively at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, complete date last worked and reason on page 1		Have premiums been paid to date for this dependent? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Was the dependent child over the Policy's limiting age? <input type="checkbox"/> Yes <input type="checkbox"/> No	Was the dependent child a full-time student? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, and required by the Policy, include school enrollment verification		Was dependent child incapacitated? <input type="checkbox"/> Yes <input type="checkbox"/> No	

### AMOUNT OF INSURANCE BEING CLAIMED FOR DEPENDENT

- Submission of claims on any voluntary or contributory Life plans, including Dependent coverage, must include copies of paper enrollment forms and/or online enrollment screen prints of current and two prior plan years for history of benefit elections and timely enrollment
- Include AD&D amount(s) only if death was due to an accident

Basic Life: \$	Supplemental Life: \$	AD&D Basic: \$	AD&D Supplemental: \$
If Supplemental Dependent Life coverage is in force, was this elected during Annual Enrollment?: <input type="checkbox"/> Yes <input type="checkbox"/> No Date elected:		Did employee complete Evidence of Insurability (EOI) for Dependent?: <input type="checkbox"/> Yes <input type="checkbox"/> No Date EOI Completed:	
Dependent benefit is a: <input type="checkbox"/> Flat Amount <input type="checkbox"/> Percentage of Employee's amount If a percentage, please complete amount of employee insurance above		Does Coverage claimed reflect age reduction(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Indicate if any of the following apply to this Employee:			
<input type="checkbox"/> Has been approved for LBO/Accelerated Death Benefits	<input type="checkbox"/> Has been Approved for Waiver of Premium		
<input type="checkbox"/> Has been Approved for Long Term Disability	<input type="checkbox"/> Applied for Conversion	<input type="checkbox"/> Applied for Portability	

### TRAVEL INFORMATION – ONLY COMPLETE FOR BUSINESS TRAVEL ACCIDENT CLAIMS

- If available, please include any travel itineraries, incident reports or police reports

Trip Begin Date: \_\_\_\_\_ Scheduled Trip End Date: \_\_\_\_\_ Injury sustained during:  Work Activity  Pleasure Activity

Amount of BTA Insurance claimed: \$ \_\_\_\_\_ Date of Accident: \_\_\_\_\_ Time of Accident (hr, min) \_\_\_\_\_: \_\_\_\_\_  AM  PM

Place of Accident: \_\_\_\_\_ Fully describe the circumstances of the Accident and nature of Injuries, if known: (Include incident/police reports as available; attach separate sheet, if necessary)

### EMPLOYER CERTIFICATION

I hereby certify that the information provided on the Employer Statement is true and complete, according to the records of the Employer. I agree that this information is subject to audit by The Hartford and/or its representative.

Employer _____	Address _____	
Signature _____	Date _____	Their Authorized Representative (Please print) _____
( ) _____	( ) _____	( ) _____
Telephone Number _____	E-mail Address _____	Facsimile Number _____

# Group Life and Accidental Death Claim Forms for EMPLOYEE or Dependent



## PART II - BENEFICIARY'S STATEMENT

- Release of claim forms is not an admission of coverage; or that a claim is payable.
- The Company reserves the right to require or to obtain further proof of information, if necessary, upon claim review.
- Please verify if employee may have qualified, was enrolled and covered, for any other group benefits through The Hartford and submit a claim accordingly. If uncertain, please contact the group policyholder/employer for assistance.

<b>GROUP POLICYHOLDER/EMPLOYER NAME:</b> _____		
Name of Insured/Employee:	Date of Birth:	Social Security Number:
Deceased's Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Partnered		
If known, please indicate the manner of death below: <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Homicide <input type="checkbox"/> Suicide <input type="checkbox"/> Pending/Undetermined/Unknown Cause (if known): _____		
<b>Please provide a copy of the death certificate with your submission. If not available, please submit as soon as possible.                  If the death was due to an accident, please note there is an additional questionnaire to complete on page 4.</b>		

## DEATH BENEFIT PAYMENT

**We will issue the full amount of the insurance proceeds payable to you by check, provided we have received all necessary documentation.**

Beneficiary Name: (print)	Date of Birth:	Relationship:
Citizenship: <input type="checkbox"/> U.S. citizen <input type="checkbox"/> U.S. resident <input type="checkbox"/> Non-resident alien (Request a W-8BEN)		
Complete Mailing Address: (Number & Street)	Beneficiary's Social Security Number or Estate /Trust Tax ID:	
(City, State & Zip Code)	E-mail address:	
Personal Cell Phone: ( ) _____ Home Phone: ( ) _____		
May we have your authorization to communicate benefit information and/or request information by e-mail? <input type="checkbox"/> Yes <input type="checkbox"/> No; or leave confidential information on your personal cell phone? <input type="checkbox"/> Yes <input type="checkbox"/> No Please initial here: _____ to confirm your elections		
<b>By signing below:</b> (1) <b>I Hereby Certify and Agree</b> that I have read and understand the IMPORTANT NOTICE page within this claim form. (2) <b>I Hereby Certify</b> that the information provided on this Beneficiary Statement is true and complete, to the best of my knowledge. (3) <b>I Understand and Agree</b> that if I receive claim proceeds which are not due to me, I will reimburse The Hartford.		
Signature: _____		Date: _____
X		

**Group Life and/or Accidental Death Claim Form  
for EMPLOYEE or DEPENDENT**



**Claimant's Statement of Accidental Death (complete only if death was due to an accident)**

- If death was due to an accident, death certificate must be submitted at time of claim
- If you do not know or have a response to a question, please indicate "Unknown"
- If a question does not apply, please indicate "N/A"

<b>Group Policyholder/Employer Name:</b> _____		
<b>Group Policy Number(s):</b> Life/AD&D: _____ AD&D: _____ Business Travel Accident: _____		
<b>Name of Insured/Employee:</b>		<b>Social Security Number:</b>
Name of Deceased: (if different from above)	Age:	Relationship to Employee: <input type="checkbox"/> Spouse <input type="checkbox"/> Child
Has a Workers' Compensation claim been filed? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," what is the status of the claim? _____		
On what date did the accident happen? _____ Where did the accident happen? City: _____ State: _____		
Please describe injuries received:		
Did accident result in death? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," on what date? _____		
If injury was sustained while traveling on policyholder/employer business, please complete the following: Trip Begin Date: _____ Scheduled Trip End Date: _____ Injury was sustained during: <input type="checkbox"/> Work Activity <input type="checkbox"/> Pleasure Activity		
<b>For all accident claims, please complete the following:</b>		
Describe in detail how the accident happened:		
Name and address of law enforcement agency involved: <i>(Please submit copy of Police Accident Report and/or Case Number)</i>		
List name/address/phone number of all physicians consulted for the injury/death:		
List name/address/phone number of all hospitals consulted:		
Did the deceased have any chronic disease or physical defect or deformity? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", describe in detail:		
Was an autopsy performed? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," provide name/address/telephone number of coroner, if known:		
Was an inquest held? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", verdict:		

**Please complete and sign the Authorization to Obtain and Disclose Information on page 6**

**Important Notice - Please read the statement that applies to your state of residence and sign the bottom of the 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 information to obtain or amend insurance coverage or to make a 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.

**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

