Group (Stand Alone) Accidental Death, Dismemberment and/or Injury Claim Form for Employee or Dependent

THE HARTFORD

IMPORTANT INSTRUCTIONS FOR COMPLETING CLAIM FORM(S)

To the Employer and Employee/Beneficiary, as applicable

We know this is a difficult time, and we want to assist you in filing your claim as quickly as possible. Please read these important instructions regarding completion of these forms. Also, please read the "Important Notice" on page 3.

The information below constitutes a complete claim filed with The Hartford for purposes of claiming Basic, Supplemental and Dependent coverage.

Part I - Employer's Statement (For All claim filings)

- ☐ Form is to be completed in its entirety and signed by the Official Representative of the Employer/Plan.
- ☐ If filing is for a death claim, a certified copy of the Death Certificate, stating cause and manner of death, must be included with the claim.
- ☐ Proof of salary as defined in the Policy (attach W2 or commissions, if applicable).
- ☐ Submission of claims on any voluntary or contributory AD&D plans, including Dependent coverage, must include copies of paper enrollment forms and/or on-line enrollment screen prints showing the history of the benefit election and timely enrollment.
- ☐ If filing is for a death claim, a beneficiary designation form(s) on file with the Employer/Plan, if any, must be included with the claim. If none on file, the Employer/Plan shall certify to that fact on the claim form.

Part II - Claimant's Statement (For All claim filings - Also refer to Miscellaneous section)

- ☐ Must be completed by claimant or beneficiary when claiming for death or dismemberment benefits due to an accident.

Part III - Beneficiary Statement (For Accidental Death claims - Also refer to Miscellaneous section)

- ☐ If more than one beneficiary, each beneficiary can either sign and date one form, or each can complete separate forms,showing their current address, date of birth and Social Security Number.

Part IV - Attending Physician's Statement (For Dismemberment/Sight/Hearing/Speech and/or Injury claims)

- ☐ Remove the Attending Physician Statement, complete the top portion and provide to your physician for the applicable claim.
  * Provide pages 7 and 8 to your Physician, request to complete and return to The Hartford.

Miscellaneous - All Claims

- ☐ Please sign the Medical Release of Information Authorization, page 4.
- ☐ Furnish, if available, police, motor vehicle Accident/Incident reports, autopsy/toxicology, hospital itemized bill (UB92) or Medicare Summanry and any other pertinent information regarding your claim.
- ☐ If the claim proceeds are payable to an Estate, Part III must be completed by the Executor or Administrator of the Estate. An official certificate of such person's legal appointment and qualification must be attached to this form. Please include the Estate Tax Identification Number. If none available, please explain.
- ☐ If any designated beneficiary is a minor, Part III must be completed by a custodian or guardian. Include the minor's social security number, also, please include a copy of the minor's birth certificate. An official certificate of the guardian's legal appointment and qualification of the minor's **estate or property** must also be included, if applicable.
- ☐ If claim is for a dependent child enrolled in an accredited school of higher learning, submitted documents should include a student enrollment verification form executed by the school, applicable if required under the Policy.
- ☐ Foreign Death - Include both the Official Death Certificate and the Death of American Citizen Abroad form. Please note that additional documents may be required upon claim review.

Submit claim by mail to: The Hartford
Group Life Claims
P. O. Box 14299
Lexington, KY 40512-4299
Fax to: 1-866-954-2621
E-Mail to: gbclaimcslife@thehartford.com

Release of claim forms is not an admission of coverage under a policy for an employer, group or organization.

HARTFORD LIFE INSURANCE COMPANY
HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

Group (Stand Alone) Accidental Death, Dismemberment and/or Injury Claim Form for EMPLOYEE or DEPENDENT

Mail forms to: The Hartford
Group Life Claims
P. O. Box 14299
Lexington, KY 40512-4299
1-888-563-1124 Fax: 1-866-954-2621
E-Mail: gbclaimcslife@thehartford.com

THE HARTFORD

PART I - EMPLOYER STATEMENT - TO BE COMPLETED IN FULL FOR ALL CLAIMS
(Please verify if the employee qualifies for any other group benefits through The Hartford and submit the claim accordingly)

Employer Name: Board of Trustees of University of IL				Group Stand Alone ADD Policy Number: ADD-S0: 5883
Name of Insured /Participant:				Social Security Number:
Insured's address: (Street, City, State & Zip Code)			Date of Birth:	Date of Death:
Branch/Location:	☐ Salaried ☐ Hourly	Date of Hire:	Effective date of employee's insurance:	Premiums paid to date? ☐ Yes ☐ No
Occupation:	Classification		Provide employee's actual date last physically at work:	

Provide reason employee did not return to work on their next scheduled workday:
☐ Illness ☐ FMLA (provide approval form) ☐ Retirement - Date:_____ ☐ Other (please explain):_____

Is there a Beneficiary Designation Card on file? ☐ Yes ☐ No If "Yes," a copy must be submitted

BENEFIT AMOUNT BEING CLAIMED FOR EMPLOYEE OR INCLUDE AMOUNT IN FORCE FOR EMPLOYEE, IF DEPENDENT CLAIM

Basic Accidental Death: $	Supplemental Accidental Death: $	**(Employee's earning as defined in the policy. Attach W-2 if applicable)** Rate of earnings used to calculate benefit amount:
List Any Additional Accidental Benefit Amount(s) Being Claimed		☐ Hourly ☐ Weekly ☐ Monthly ☐ Annually
Accidental Dismemberment: $	Other: $	Regular hours scheduled to work: (if applicable)
Coverage claimed above, reflect age reduction(s)? ☐ Yes ☐ No		Effective date of above reported earnings:
Date insurance was discontinued or not in force		Do the earnings include commissions or bonuses? ☐ Yes ☐ No

Indicate if any of the following apply to this Employee:
☐ Applied for Conversion
☐ Has been approved for LBO/Accelerated Death Benefits by prior carrier
☐ Has been approved for Long Term Disability
☐ Has been approved for Waiver of Premium by prior carrier

Note: Changes in amounts of coverage, or increases in coverage, may not apply if the employee was absent from work due to illness or injury on the effective date. Changes in amounts of coverage and increases are deferred until employee returns to active full-time work. If the employee elected increases in coverage during the past two years, the amount being claimed reflects the increase, attach copies of the election forms.

State name and amounts of other insurance policy(ies), if any.

DEPENDENT INFORMATION - ONLY COMPLETE FOR DEPENDENT CLAIM

Full Name of Insured Dependent	Dependent's Social Security Number	Date of Birth	Date of Death	Relationship to Employee
Residence: (Number, Street, City or Town, Zip Code)	Is Employee Actively at Work? ☐ Yes ☐ No If no, complete date last worked and reason above		Have premiums been paid to date for this dependent? ☐ Yes ☐ No	
Insured dependent child, over the Policy's limiting age? ☐ Yes ☐ No	Insured dependent child a full-time student? ☐ Yes ☐ No If "Yes", and required by the Policy, include Enrollment verification from school.		Insured dependent child incapacitated? ☐ Yes ☐ No	

AMOUNT OF INSURANCE BEING CLAIMED FOR DEPENDENT

Basic Accidental Death: $	Supplemental Acidental Death: $	Dependent benefit is a: ☐ Flat Amount ☐ Percentage of Employee's amount If a percentage, please complete amount of employee insurance above.
List Any Additional Accidental Benefit Amount(s) Being Claimed, if applicable under the Policy		Does Coverage claimed reflect age reduction(s)? ☐ Yes ☐ No
Accidental Dismemberment: $	Other: $	Indicate if any of the following apply to this Dependent: ☐ Applied for Conversion ☐ Has been approved for LBO/Accelerated Death Benefits by prior carrier ☐ Has been approved for Waiver of Premium by prior carrier

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 Hartford Life Insurance Company or Hartford Life and Accident Insurance Company and/or its representative.

Employer _____ Address _____

Signature _____ Date _____ Their Authorized Representative: (Please print) _____

( ) _____ _____ ( ) _____

Telephone Number E-mail address Facsimile Number

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, California, Colorado, Florida, Kentucky, Maine, Maryland, New Jersey, New York, Oregon Pennsylvania, Puerto Rico, Tennessee 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 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 nformation 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 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 _____

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

To: Any health care provider, pharmaceutical provider, pharmacy benefits manager, employer, benefit plan, insurer, service provider, financial institution, 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[1] a complete copy of, and to communicate telephonically or electronically with The Hartford's representatives about, any and all of the following personal, private, or privileged information, records, or documents relative to:

Insured's Name (*Please print*)	Date of Birth	Last 4 Digits of Social Security Number

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 drug abuse, and mental health; 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 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 and/or request for accommodation. 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 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 restrictions/limitations, including in accordance with law; b) responding to claims related to accommodation or adverse or discriminatory treatment related to my claim or condition; c) responding to complaints by me or my representative relating to benefits or leave or accommodation; d) responding to any litigation, agency or regulatory proceeding, 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 or other audits or reviews; (ii) to the administrator 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 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, 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; (ix) as may be reasonably necessary to respond to regulatory complaints; and (x) as may be reasonably necessary to prevent or detect perpetration of a fraud.

I ALSO 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(ies) or benefit plan or program, except as may be reasonably necessary to prevent or detect perpetration of a fraud, respond to regulatory complaints, 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, Beneficiary or Authorized Representative	Date (Valid for 2 years)	Relationship to Insured *(if signed by Authorized Representative)*

[1] The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries and their affiliates

Group (Stand Alone) Accidental Death, Dismemberment and/or Injury Claim Form for EMPLOYEE or DEPENDENT

PART II - CLAIMANT'S STATEMENT
TO BE COMPLETED FOR ALL CLAIMS

Mail Forms to: The Hartford
Group Life Claims
P.O. Box 14299
Lexington, KY 40512-4299
1-888-563-1124 Fax: 1-866-954-2621
E-Mail: gbclaimcslife@thehartford.com

THE HARTFORD

INSTRUCTIONS: Complete this form when applying for Death, Dismemberment and/or Injury benefits due to an Accident.
If a question does not apply, please indicate "N/A"

Group Policyholder/Employer Name Board of Trustees of University of IL	**Policy Number** ADD-S05883
Name of Insured Employee/Participant	Social Security Number
Name of Deceased or Injured (if different from above)	Deceased/Injured Social Security Number:
Deceased or Injured Person's Address (if different from above)	Relationship to Employee: ☐ Self ☐ Spouse ☐ Child

On what date did the accident occur?_____ Where did the accident happen? City _____ State _____
Describe in detail how the accident occured:

Name and address of law enforcement agency involved - Case Number:_____ (Please submit copy of Police Accident Report)

Please describe all injuries received that resulted in death and/or hospital confinement

Has a Workers' Compensation claim been filed? ☐ Yes ☐ No If "Yes," what is the status of the claim?_____

Did the deceased/injured have any chronic disease or physical defect or deformity? ☐ Yes ☐ No If "Yes," describe in detail:

List all physicians consulted for care due to this injury/death

NAME	ADDRESS	TELEPHONE NO.	PERIOD TREATED
		( )	To: From:
		( )	To: From:
		( )	To: From:

List all hospital where confined for care due to this injury/death

NAME	ADDRESS	TELEPHONE NO.	PERIOD CONFINED
		( )	To: From:
		( )	To: From:
		( )	To: From:

PLEASE ATTACH COPY OF ITEMIZED HOSPITAL BILL, UB92 OR MEDICARE SUMMARY (if applicable)

Did accident result in death? ☐ Yes ☐ No If "Yes" on what date?_____
Was autopsy performed? ☐ Yes ☐ No If "Yes" provide name/address/telephone number of coroner, if known:

Was an inquest held? ☐ Yes ☐ No If "Yes" verdict?_____

Claimant's Name	Date of Birth	Your relationship to deceased or injured
Claimant's Address		Claimant's E-Mail Address

Phone Numbers Daytime: ( ) Evening: ( ) Personal Cell Phone 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

SIGNATURE OF PERSON COMPLETING THIS FORM	DATE

(Note: if other than beneficiary, attach appropriate legal documents substantiating your authority.)
Please sign and date the Medical Release of Information Authorization on page 4.

Group (Stand Alone) Accidental Death, Dismemberment and/or Injury Claim Form for Employee or Dependent

THE HARTFORD

PART III - Beneficiary's Statement

Name of Deceased: ______________________ **Policy Number(s):** ADD-S05883

Claim Number (if known): ______________

Under penalties of perjury, I certify that:

(1) the number shown on this form is my correct taxpayer identification; and

(2) I am not subject to a back-up withholding, because, (a) I am exempt from back-up withholding; or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest and dividends; or (c) the IRS has notified me that I am no longer subject to back-up withholding; and

(3) I am a U.S. person (including a U.S. resident alien).

Certification Instructions: You must cross out item (2) above, if you have been notified by the IRS that you are currently subject to back-up withholding, because, you have failed to report all interest and dividends on your tax return.

By signing below:

(1) **I Hereby Certify and Agree** that I have read and understand the IMPORTANT NOTICE on page 3 of this claim form package.

(2) **I understand and Agree** that payment of the claim proceeds according to any alternate mode of settlement specified in the policy will only be made if the Company receives a written request for such alternate method of payment from me prior to the payment of the claim proceeds.

Beneficiary Name: (print) | Date of Birth: | Relationship:

Citizenship: ☐ U.S. citizen ☐ U.S. resident ☐ 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) | Telephone Number: Day: ( ) 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

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

Signature: X | Date: | E-mail address:

Beneficiary Name: (print) | Date of Birth: | Relationship:

Citizenship: ☐ U.S. citizen ☐ U.S. resident ☐ 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) | Telephone Number: Day: ( ) 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

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

Signature: X | Date: | E-mail address:

Beneficiary Name: (print) | Date of Birth: | Relationship:

Citizenship: ☐ U.S. citizen ☐ U.S. resident ☐ 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) | Telephone Number: Day: ( ) 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

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

Signature: X | Date: | E-mail address:

THE HARTFORD

PART IV - ATTENDING PHYSICIAN'S STATEMENT

Please print - Use a separate sheet of paper, if necessary
(Physician's Certification on Page Two)

Patient's Name	Date of Birth	Social Security Number	
Address	City	State	Zip Code

Provide a description of the injuries received by the patient in the accident and the primary diagnosis:

On what date did you first examine and treat the patient for this injury?

Describe the affected body part(s) due to the injury	Date of injury

What complications, if any, have arisen?

Had patient previously had medical attention for this injury? ☐ Yes ☐ No If "Yes," by whom?

Was the injury described above, of itself, and independent of all other causes,solely responsible for the loss? ☐ Yes ☐ No

If "No", give the particulars of any contributing cause(s):

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

Was claimant under the influence of alcohol and/or other drugs at the time of the accident or injury? ☐ Yes ☐ No ☐ Unknown

Was surgery performed due to the injury? ☐ Yes ☐ No Date of surgery

Name of Surgeon

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

Hospital Information

Was the patient confined to a hospital due to the injury? ☐ Yes ☐ No

Hospital Name			
Hospital Address			
Date of Admission:	Date of Discharge	Reason for hospitalization	☐ Inpatient ☐ Outpatient
Hospital Name			
Hospital Address			
Date of Admission:	Date of Discharge	Reason for hospitalization	☐ Inpatient ☐ Outpatient

Coma - Means complete unconsciosness with inability to respond to external or internal stimuli for a continuous period.

Did Patient's injury result in a Coma? ☐ Yes ☐ No

Date Coma Began_____ Date Coma Ended _____ or Current Duration_____days
Was the Coma Confirmed by EEG? ☐ Yes ☐ No

Note: Continue on next page for other losses.

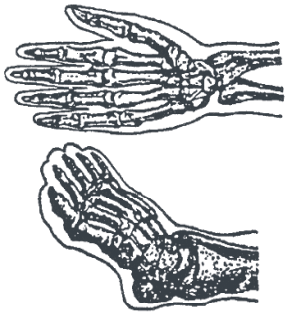
ACCIDENTAL DISMEMBERMENT AND/OR INJURY FILING ONLY

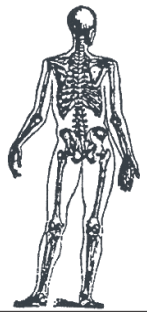
ATTENDING PHYSICIAN'S STATEMENT - Cont.

Accidental Dismemberment

If the injury described above caused an amputation or loss of body usage, is this amputation or loss irrecoverable? ☐ Yes ☐ No

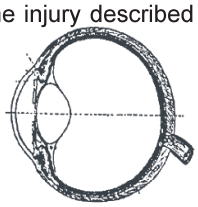
If "No", please explain: _____





Please indicate location of amputation or area of injury on the left side chart. Add any necessary comments below.

Loss of Sight - If the injury described above caused loss of sight, please provide copies of vision test and complete below:

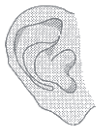


Indicate best corrected visual acuity and/or area of injury as of _____ (Date).

Right eye:	_____ Corrected	_____ Uncorrected
Left eye:	_____ Corrected	_____ Uncorrected

Is this loss of sight (due to injury) irrecoverable?
☐ Yes ☐ No

Loss of Hearing



In your medical opinion, has this patient sustained complete and irrecoverable hearing loss due to an injury?
☐ Yes ☐ No ☐ Right ☐ Left ☐ Both

Please provide copies of auditory test results.

Loss of Speech

In your medical opinion, has this patient sustained complete and irrecoverable loss of speech due to an injury?
☐ Yes ☐ No

Please provide copies of speech test results.

Physician Information and Certification

Physician Name (please print):		
Specialty	License Number	EIN/Tax ID# or SSN
Street Address:	City/Town	State/Province: Zip Code:
Telephone Number: ( )	Fax Number: ( )	
Physician's Signature:	Date:	

Please return completed form(s) to:
The Hartford
Group Life Claims
P. O. Box 14299
Lexington, KY 40512-4299
Fax to: 1-866-954-2621
E-Mail to: gbclaimcslife@thehartford.com