Clear Form

HARTFORD FIRE INSURANCE COMPANY
HARTFORD LIFE INSURANCE COMPANY
HARTFORD LIFE & ACCIDENT INSURANCE COMPANY

THE HARTFORD

Notice of Claim

The Regents of the University of California Cooperative Extension

Hartford Life Claims, P.O. Box 3856, Alpharetta, GA 30023 Toll Free (800) 678-6702 Fax (866) 954-3993

POLICYHOLDER CERTIFICATION - To be completed by Policyholder Official (UC 4-H YDP Staff)

**Due to new government regulations, claims submitted without this data will be returned.*

Policyholder Number

☐ **57 SR 560999 - Acc** ☐ **57 CH 144856 - Sickness**

Policyholder Name	Policyholder Phone Number
The Regents of the University of California Cooperative Extension	**(530) 754-8518**
Agent Name	Agent Phone Number
Dealey, Renton & Associates	**(800) 545-3090 Ext: 275**

Claimant (Injured Party) Name	Claimant Gender	Claimant Date of Birth
	☐ Male ☐ Female	

*Is the Claimant a Medicare Beneficiary? ☐ No ☐ Yes

If yes, please provide Claimant's Social Security Number or Health Identification Claim Number _____

Claimant Address (Street Number, City, State & Zip Code)	Claimant Phone Number
	( )

Date of Accident	Time of Accident (hh:mm)	Indicate injured body part(s)
_____ (mm/dd/yyyy)	_____ ☐ AM ☐ PM	

Cause of Accident	Place of Accident

Witness to the Accident (Name)	Supervisor of the activity

Nature of Sickness (if applicable)	Date Sickness first commenced

Policyholder Certification Signature Required

I hereby certify the Claimant is a volunteer or a member of the group insured under the above Policy and the injury/sickness was sustained under adequate supervision while participating in an official Covered Activity. I further certify I have **read and signed** the Fraud Warning statement located on the bottom of this form.

Title of Policyholder Official (UC 4-H YDP Staff)	Signature of Policyholder Official (UC 4-H YDP Staff)	Date

FRAUD WARNING CERTIFICATION - To be signed by Policyholder, Adult Volunteer/Witness and Parent/Guardian or Adult Claimant.

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.

Signature of Policyholder Official (UC 4-H YDP Staff)	Date
Signature of UC 4-H Adult Volunteer/or Adult Witness	Date
Signature of Parent/Guardian or Adult Claimant	Date