## How to File a Medical Claim

(For Special Risk, Sports, Campers, Youth Groups, and Tripster Policies)



Attached is a Blanket Lines Notice of Claim (Claim Form) for your accident policy Please forward claims and questions to the following address:

Hartford Life Claims
Blanket Lines Unit
P.O. Box 3856
Alpharetta, GA 30023
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 the Parent, Claimant or Agent) should:

- Fully answer/sign each item in the Policyholder Certification section.
- Read and sign the Fraud Warning Certification statement located on the reverse side of the Notice of Claim.

#### The Parent/Guardian or Adult Claimant should:

- Fully answer/sign each item in the Claimant Certification section (choose either the Parent/Guardian column or the Adult Claimant column; which ever is applicable).
- Read and sign the Fraud Warning Certification statement located on the reverse side of the Notice of Claim.

Step 2 - Submit itemized medical bills for payment consideration to our office. If the policy is Excess, (please consult with Policyholder or our office if you are unsure of this) also include any other insurance carrier's corresponding Explanation of Benefits (EOBs) as outlined in the helpful information bullet listed below.

### Helpful information for submitting claims and expediting payment

- A <u>fully completed</u> Notice of Claim is required for each accident/injury a Claimant incurs. Claims submitted with incomplete information will be denied pending receipt of the missing data.
- Release of claim forms by an insurance company is not an admission of coverage. In addition, information on the form is subject to audit by the insurance company.
- 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.
- <u>Itemized</u> 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 LIFE INSURANCE COMPANY HARTFORD LIFE & ACCIDENT INSURANCE COMPANY Notice of Claim



FOR SPECIAL RISK, SPORTS, CAMPERS, YOUTH GROUPS & TRIPSTER POLICIES
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

Policyholder Number	Agent Name		Age (	Agent Phone Number ( )	
Policyholder Name			Polic (	Policyholder Phone Number	
Policyholder Address (	Street, City, State & Zip Code)				
Claimant (Injured Party	v) Name	Date of Accident:	(mm/dd/yyyy)	Time of Accident (hh:mm) AM PM	
Place of Accident	Cause of Accident		Indicate injure	d body part(s)	
Nature of Sickness (if a	applicable)		Date	e sickness first commenced	
Policyholder Certification	on Signature Required:		'		
I hereby certify the Claimant is 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 <b>read and signed</b> the Fraud Warning statement located on the reverse side of this form.					
Title of Policyholder Of	ficial Sig	nature of Policyholder C	Official	Date	

### **CLAIMANT CERTIFICATION -** To be completed by Parent/Guardian or Adult Claimant

*Due to new government regulations, claims submitted without this data will be returned.					
Parent/Guardian completes for dependent child	Adult Claimant completes				
Claimant (Dependent child) Name  Claimant Gender  Male Female	Claimant Name Claimant Gender  Male Female				
*Is the Claimant a Medicare Beneficiary?   No Yes If yes, please provide Claimant's Social Security Number or Health Identification Claim Number	*Is the Claimant a Medicare Beneficiary?   No Yes If yes, please provide Claimant's Social Security Number or Health Identification Claim Number				
Claimant Date of Birth Daytime Phone Number	Claimant Date of Birth Daytime Phone Number				
Claimant Address (Street Number, City, State, Zip)	Claimant Address (Street Number, City, State, Zip)				
Does the Claimant have medical coverage through?	Do you have medical coverage through?				
Mother's employers policy* ☐ Yes ☐ No	Spouse's employer* Yes No				
Father's employers policy* Yes No	Your employer*				
Guardian's employers policy* Yes No	Medicare policy Yes No				
Medicare policy Yes No	Medicaid policy Yes No				
Medicaid policy Yes No	Any other medical policy* Yes No				
Any other medical policy* Yes No					
If yes, and this Policy is Excess, please include the other insurance carrier's Explanation of Benefits (EOBs) for each medical bill submitted.	If yes, and this Policy is Excess, please include the other insurance carrier's Explanation of Benefits (EOBs) for each medical bill submitted.				
Parent/Guardian or Adult Claimant Certification Signature Re	equired:				
I certify the above information to be true and accurate to the best of my knowledge. I further certify I have <b>read and signed</b> the Fraud Warning Certification statement located on the reverse side of this form. I also authorize any physician / hospital that has attended me or my dependent child to disclose information acquired for claim payment purposes.					
Printed Name Parent/Guardian or Adult Claimant					
Signature of Parent/Guardian or Adult Claimant	Date				

#### FRAUD WARNING CERTIFICATION

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

For residents of all states EXCEPT California, Colorado, Florida, Kentucky, Maine, 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 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, Virginia 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 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 benefit 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 with the penalty of 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 are 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.

I hereby certify the foregoing statements made by me on this form to be that if any of the foregoing statements on this form made by me are will may include criminal prosecution.	, ,
Signature of Policyholder Official	Date
Signature of Parent/Guardian or Adult Claimant	Date