HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
Procedures for Master Gardener/Master Food Preserver Claims

MG/MFP Volunteer Injured Party

This insurance covers enrolled Master Gardener/Master Food Preserver volunteers who are injured while participating in or traveling to or from an approved, regularly supervised Master Gardener/Master Food Preserver activity. See the brochure for actual coverage amounts.

Forms are available at http://ucanr.edu/sites/risk/Forms_and_Waivers/ or http://camastergardeners.ucdavis.edu/

Step 1: Complete the Claim Form (Injured party)

Claimant (Injured party) Name
Date of Accident
Time of Accident
Place of Accident
Cause of Accident
Injured Body Part
Nature of Sickness (if applicable)

Claimant Name
Claimant Gender
Claimant Medicare Beneficiary
Claimant Date of Birth
Daytime Phone Number
Claimant Address
Medical Coverage through
Claimant confirms the information by signing and dating form and the Fraud Warning certification box.

Step 2: Include relevant materials with the Claim Form

- A copy of the itemized bill(s) from the medical services must be attached to the Claim Form. If you paid for the services, please indicate that you paid for these services, by providing proof of payment and indicate that remittance should go to you and not the service provider. Please keep copies of all documents for your records.

Step 3: Submit the Claim Form and Itemized Bills to the UCCE Master Gardener/Master Food Preserver Office. (UCCE Office)

- The UCCE MG/MFP staff will sign the form under Policyholder Certification and in the Fraud Warning Certification Box and will process and submit the claim to the Hartford Claims Office.
- The payment from The Hartford is usually sent to the claimant who is responsible for the payment of bills.
- This process takes from 6-8 weeks once the claim has been sent to The Hartford.

Hartford Life Claims
Blanket Lines Unit
P.O. Box 3856
Alpharetta, CA 30023
Toll Free Number: (800) 678-6702
Fax Number: (866) 954-3993

Clear Form

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	Agent Phone Number
57-SR-562277	Dealey, Renton & Associates	(510) 465-3090

Policyholder Name	Policyholder Phone Number
UNIVERSITY OF CALIFORNIA MASTER GARDENER PROGRAM	(530) 752-7481

Policyholder Address (Street, City, State & Zip Code)
UC ANR Risk & Safety Services, Ag. Field Station Bldg., One Shields Ave., Davis, CA 95616

Claimant (Injured Party) Name	Date of Accident: (mm/dd/yyyy)	Time of Accident (hh:mm) ☐ AM ☐ PM

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

Nature of Sickness (if applicable)	Date sickness first commenced

Policyholder Certification 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 **read and signed** the Fraud Warning statement located on the reverse side of this form.

Title of Policyholder Official _____ Signature of Policyholder 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?

Mother's employers policy*	☐ Yes	☐ No
Father's employers policy*	☐ Yes	☐ No
Guardian's employers policy*	☐ Yes	☐ No
Medicare policy	☐ Yes	☐ No
Medicaid 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.

Do you have medical coverage through?

Spouse's employer*	☐ Yes	☐ No
Your employer*	☐ Yes	☐ No
Medicare policy	☐ Yes	☐ No
Medicaid 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.

Parent/Guardian or Adult 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 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 true to the best of my knowledge. I am aware that if any of the foregoing statements on this form made by me are willfully false, I may be subject to penalties, which may include criminal prosecution.

Signature of Policyholder Official _____ Date _____

Signature of Parent/Guardian or Adult Claimant _____ Date _____