

Statement of Claim
Hospital Indemnity



HARTFORD FIRE INSURANCE COMPANY
HARTFORD LIFE INSURANCE COMPANY
HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

To Be Completed By Administrator Of Insurance Plan (Not to be completed by Insured Member)

Name of Insured Member Paid to date
Patient Name Relationship
Name of Organization Policy # Cert. #
Benefits: Member Spouse Child
Orig. Eff. Date: Member Spouse Child
Chg. Eff. Date: Member Spouse Child
Claim Date Signed for Organization _____
(Administrator)

To Be Completed By Insured Member - - Fill In This Portion Completely

Name of Insured Member Social Security Number
Date of birth (Mo., Day, Yr.)
 Single Married Male Female Spouse's Date of birth (Mo., Day, Yr.)

If claim is filed for an eligible dependent, include the following information:

(a) Name of dependent Date of birth (Mo., Day, Yr.)
(b) Relationship to Insured Member Married Single
(c) Is dependent a full-time student? Yes No

If yes, give name and address of school

Date of accident or illness Nature of injury or illness

Has claim been filed for Workers' Compensation Benefits for this disability? Yes No

If you (or dependent) have been confined in a hospital as an inpatient, give date of confinement.

From to

Name and address of hospital

Name and address of attending physician(s) or surgeon(s)

Give date of first treatment

Have you (or dependent) previously been treated for or suffered from this or a related illness or injury? Yes No

If yes, state when, and give name and address of physician or surgeon who treated you or your dependent at that time

Name of Association or Organization

Do you have another Insurance Carrier? Yes No

If yes, give name and address of Carrier, and give amount of Daily Benefits.

Amount \$

I HEREBY AUTHORIZE any Insurance Company, Organization, Employer, Hospital, Physician, Surgeon or Pharmacy to release any information requested by The Hartford or its representative. A photostatic copy of this authorization shall be considered as effective and valid as the original.

Signature of patient (or parent if patient is minor) _____ Date _____

Address _____

I HEREBY AUTHORIZE PAYMENT directly to the below named hospital of the Hospital Benefits, otherwise payable to me but not to exceed the balance due of the hospital's regular charges for this period of hospitalization. I understand that I am financially responsible to the hospital for charges not covered by this authorization.

Signature of Insured _____ Date _____

Hospital Name and address _____

PLEASE READ AND SIGN LAST PAGE

PLEASE ATTACH COPY OF ITEMIZED HOSPITAL BILL.

ATTENDING PHYSICIAN'S STATEMENT- HEALTH INSURANCE CLAIM-GROUP OR INDIVIDUAL

Patient's Name and Address

Diagnosis and Concurrent Conditions (if Fracture or Dislocation, Describe Nature and Location)

When did symptoms first appear or accident happen? Date
When did patient first consult you for this condition? Date
Has patient ever had same or similar condition? Yes No
(if "Yes," state when and describe)

Nature of Surgical Procedure, if any.
(Describe Fully)

Date Performed

If performed in hospital, give name of hospital.

Inpatient Outpatient

Give dates of other medical (non-surgical) treatment, if any.

Office
Home
Hospital
Nursing Home

If illness diagnosed as Cancer, has patient been informed? Yes No
If "Yes," give date diagnosis of Cancer confirmed Date

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

To your knowledge, does patient have other health insurance or health plan coverage? If "Yes," identify. Yes No

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

Has patient been treated for this illness/injury in the past 12 months? Yes No
If "Yes," give date(s). Date(s) of Treatment

Date Signature (Attending Physician) Degree Telephone

Street Address City or Town State or Province Zip Code

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

For residents of all states **EXCEPT**: Arkansas, California, Colorado, Florida, New Jersey, New Mexico, Pennsylvania and Virginia: 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 substantial civil penalty where and to the extent allowed by state law.

For residents of Arkansas, New Jersey and New Mexico: 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 CALIFORNIA: FOR YOUR PROTECTION CALIFORNIA LAW REQUIRES THE FOLLOWING TO APPEAR ON THIS FORM: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR THE PAYMENT OF 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 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 damage. Any insurance company or its agent who knowingly provides false, incomplete, or misleading information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to settlement or award shall be reported to the Colorado Division of Insurance.

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 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 thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Signature

Date