



Hartford Life

HARTFORD LIFE INSURANCE COMPANY
HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
PROOF OF DEATH - DEPENDENT (Group Life Insurance)

IN FURNISHING THIS FORM HARTFORD LIFE DOES NOT WAIVE ANY OF ITS RIGHTS OR DEFENSES NOR ADMIT LIABILITY

STATEMENT OF EMPLOYER (Please submit a copy of the enrollment form with each claim.)

EMPLOYEE INFORMATION
Full Name of Employee (Last, first, middle initial)
Employee Social Security Number
Last Residence (No. Street, City or Town, State, Zip Code)
Employer
Branch or Subsidiary
Occupation
Classification
Date Employed
Policy Number
Effective Date of Employee's Insurance
Have premiums been paid to date for this employee?
Date of Birth
Is Employee Actively at Work?
If "No," indicate Date Last Worked and Reason:
Rate of basic earnings on date last worked?
Do the earnings include commissions and bonuses?
AMOUNT OF INSURANCE IN FORCE ON EMPLOYEE
Basic Life
Supplemental Life
AD&D Basic
AD&D Supplemental

DEPENDENT INFORMATION
Full Name of Deceased Dependent (Last, first, middle initial)
Last Residence (No. Street, City or Town, State, Zip Code)
Dependent Social Security No.
Dependent Date of Birth
Dependent Date of Death
Relationship to Employee
Effective Date of Dependent Insurance
Have premiums been paid to date for this dependent?
Was the dependent over age 19?
Was the dependent a full-time student?
AMOUNT OF INSURANCE BEING CLAIMED FOR DEPENDENT
Basic Life
Supplemental Life
AD&D Basic
AD&D Supplemental
Is the dependent benefit a:
Do age reductions in Spouse's coverage apply?
Was an LBO/Accelerated Death Benefit ever approved 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, or if the dependent was confined at home, in a hospital, or elsewhere on the effective date.

PLEASE SEE REVERSE SIDE OF FORM FOR EMPLOYER CERTIFICATION

Safe Haven Account

If your claim is approved and exceeds the current applicable minimum set by the Company, an interest-bearing checking account will be opened for you, and you will promptly receive your personalized checks. You may immediately utilize all or a portion of those funds by writing your checks against that account. The funds in the account will earn interest at a competitive rate.

BENEFICIARY CERTIFICATION (Note: If any beneficiary entitled to benefits is deceased, obtain official copy of Death Certificate.)

I hereby certify that the information provided by me in this Proof of Death form is true and complete to the best of my knowledge and belief, and I have read and understand the statements on the reverse side. Pursuant to IRS Form W-9, Request for Taxpayer Identification Number and Certification, I certify under penalties of perjury that the Social Security Number on this form is correct. I am not subject to IRS back-up withholding.

Name of Beneficiary
Date of Birth
Relationship to Employee
Address of Beneficiary
No. Street City or Town State/Zip Code
Signature of Beneficiary
Social Security Number
Telephone (Day)
Telephone (Evening)

DOCUMENT VERIFICATION

To ensure prompt handling of this claim, please consider all of the following documents which should be included with this claim submission, where applicable:

- Certified Death Certificate
- Enrollment card
- Beneficiary Designation Form
 - If beneficiary is a minor, certified guardianship papers for the estate of the minor beneficiary must be provided.
 - If payment is to be made to an estate, certified estate papers must be submitted.
 - If payment is to be made to the estate, are you requesting a Form 712? Yes No
- Form W-2 (if benefit is based on prior years' earnings)
- NY State Tax Waiver {if benefit is more than \$50,000.00 and payable to a beneficiary other than a spouse (NY State only)}
- Medical Authorization (if applicable)
- Family Leave Approval Form (if employee was out on family leave)
- Documentation of full-time student status (if over age 19)

For residents of all states EXCEPT California, Florida, New Jersey, Colorado, Pennsylvania, Arkansas, New Mexico, Louisiana, Oregon, and Virginia: A person commits a fraudulent insurance act if that person knowingly, and with intent to defraud any insurance company or other person, either: (a) files an application for insurance or statement of claim containing any materially false information, or (b) conceals information concerning any material fact in order to obtain an insurance policy or a benefit under an insurance policy. **A fraudulent insurance act is a crime.** The Hartford shall pursue prosecution of any fraudulent insurance act to the fullest extent of the law.

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 New Jersey, Arkansas, New Mexico, and Louisiana: 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 an insurance policy is subject to criminal and civil penalties.

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 a person to criminal and civil penalties.

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 damages. 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 an insurance settlement or award shall be reported to the Colorado Division of Insurance.

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 A LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON.

EMPLOYER CERTIFICATION:

*I hereby certify that the information provided 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 representatives.*

Dated _____ Address _____

(Employer) By _____ (Their Authorized Representative) (Please print) _____ (Signature)

() _____
(Telephone Number)