Business Travel Accident
Statement of Claim for
Travel Loss Benefits

IMPORTANT INSTRUCTIONS FOR COMPLETING CLAIM FORM(S)

To the Policyholder and Claimant:

We want to assist you in filing your claim as quickly as possible. Please read these important instructions regarding completion of these forms. Also, please read the "Important Notice" on page 4.

The information below constitutes a complete claim filed with The Hartford for purposes of claiming Travel Loss benefits under a Business Travel Accident policy.

Part I – Policyholder's Statement

- ☐ Form is to be completed in its entirety and signed by the Official Representative of the Policyholder/Plan.
- ☐ Provide any Required Attachments (see Section D).

Part II – Claimant's Statement

- ☐ Form is to be completed in its entirety and signed by the individual or representative of the party claiming benefits.
- ☐ Review the Required Attachments and Signature section of the Claimant's Statement (see Section C), and submit the necessary items depending on the benefit claimed. Failure to include the Required Attachments may delay the processing of your claim.
- ☐ Read and sign the Important Notice on page 4.

Please detach this page and forward the completed Statement of Claim and required attachments to the address listed below. We recommend you retain copies of the items you have submitted for future reference.

Submit claim by mail to: The Hartford
P.O. Box 14299
Lexington, KY 40512-4299
Fax to: 1-866-954-2621
Phone: 1-888-563-1124
Email to: gbclaimcslife@thehartford.com

Release of claim forms is not an admission of coverage under a policy for a policyholder, group, or organization. Please verify if the insured qualifies for any other group benefits through The Hartford and submit the claim accordingly.

PLEASE SEE THAT ALL SECTIONS ARE FULLY COMPLETED AND SIGNED.

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PART I - POLICYHOLDER'S STATEMENT – To be completed by the Official Representative of the Policyholder/Plan

A. Information About the Policyholder

Policy Number:	Policyholder Name:	
Policyholder Email Address:	Policyholder Telephone Number: ( )	Policyholder Fax Number: ( )
Policyholder Address (Street, City, State, & Zip Code):		
Branch/Location (or "n/a" if this does not apply):		

B. Information About the Party Claiming Benefits

Party claiming benefits is ☐ Employee ☐ Policyholder/Participating Organization			
If Employee is claiming benefits, complete the following:			
Employee Name:		Employee DOB:	Employee Social Security Number:
Employee Address (Street, City, State, & Zip Code:			Employee Telephone Number: ( )
Date of Hire:	Occupation/Job Title:		Class (or "n/a" if this does not apply:

C. Information About the Claim

Benefits claimed due to (check all that apply):
☐Trip Cancellation ☐Trip Delay ☐Checked Baggage Delay ☐Personal Liability ☐Personal Monetary Loss
☐Trip Interruption ☐Trip Change ☐Lost, Stolen, or Damaged Baggage ☐Court Attendance ☐Personal Property

Scheduled Start Date of Trip:	Scheduled End Date of Trip:	Trip Origination and Destination:
Describe the purpose of the Trip:		
For Personal Liability, Court Attendance, Personal Monetary Loss, and Personal Property Claims, complete the following:		
Date of Incident:	Time of Incident (hh:mm): ☐ AM ☐ PM	Place of Incident:
Fully describe the circumstances of the incident resulting in the claim for benefits (Use a separate sheet of paper, if necessary):		

D. Required Attachments and Signature

Please attach copies of the following documents as applicable:

- Itineraries, policyholder travel receipts, etc. related to the trip.
- Incident/police reports, if available.

I hereby certify the Insured is a member of the group insured under the above Policy and the loss was sustained while participating in an official Covered Activity.

I certify that the information provided on the Policyholder's Statement is true and complete according to the records of the Policyholder. I agree that this information is subject to audit by The and/or its representative.

Title of Policyholder Official	Signature of Policyholder Official	Date

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PART II – CLAIMANT'S STATEMENT – To be completed by the Claimant (BE SURE TO ANSWER ALL QUESTIONS)

A. Information About the Party Claiming Benefits

Party claiming benefits is ☐ Employee ☐ Policyholder/Participating Organization		
If Employee is claiming benefits, complete the following:		
Employee Name:	Employee DOB:	Employee Social Security Number:
Employee Address ((Street, City, State, & Zip Code):		Employee Telephone Number: ( )
If Policyholder/Participating Organization is claiming benefits, complete the following:		
Name of Policyholder/Organization to be paid:	Telephone Number: ( )	Tax ID Number of Payee:

B. Information About the Claim

For claims related to a Trip Cancellation, Interruption, Delay, or Change, and for Baggage claims, complete the following:

Benefits claimed due to (check all that apply):

☐ Trip Cancellation – date trip cancelled: _____
☐ Trip Interruption – date trip ended: _____
☐ Trip Delay – number of hours delayed: _____
☐ Trip Change Penalty

Reason for Cancellation, Interruption, Delay, or Change:

Fees/Costs claimed (check all that apply):

☐ Travel Ticket/Arrangement fees Amount claimed: $_____
☐ Accommodation fees Amount claimed: $_____
☐ Expenses due to delay Amount claimed: $_____
☐ Trip Change Penalty fees Amount claimed: $_____

Was Checked Baggage Delayed? ☐ Yes ☐ No
☐ Expenses for purchase of Personal Effects: $_____
☐ Baggage Delivery Expenses: $_____

Was Baggage Lost, Stolen, or Damaged? ☐ Yes ☐ No
☐ Expenses claimed to replace items: $_____
☐ Expenses claimed to repair items: $_____

For claims for the Personal Liability Benefit and/or Court Attendance Benefit, complete the following:

Indicate the fees incurred by the Policyholder/Participating Organization due to legal liability for the following:

☐ Damages for bodily injury: Amount claimed: $_____
☐ Damages for property loss or damage: Amount claimed: $_____
☐ Expenses for court attendance: Amount claimed: $_____

For claims for the Personal Monetary Loss Benefit and/or Personal Property Loss Benefit, complete the following:

Type of Loss:

☐ Physical loss or theft of money Amount claimed: $_____
☐ Lost, stolen, or accidentally damaged Personal Property Amount claimed: $_____
☐ Lost, stolen, or accidentally damaged Business Equipment Amount claimed: $_____
☐ Fraudulent use of credit, debit, or charge cards Amount claimed: $_____
☐ Fraudulent use of mobile payment technology Amount claimed: $_____
☐ Fraudulent use of mobile phone Amount claimed: $_____

C. Required Attachments and Signature

Please attach copies of the following documents as applicable:

Trip-related claims:
- Receipts for any paid, non-refundable, and non-credited fees.
- Physician certification supporting the cancellation or interruption due to injury or sickness
- Obituary or other proof of death of Insured or Immediate Family Member.
- Other satisfactory proof of the cited reason to cancellation, interruption, or delay.

Baggage claims:
- Initial report and claim submitted to the Common Carrier and any other insurer and the results of any settlement or denial of claim.
- Receipts for any paid purchases of personal effects or delivery fees due to Baggage Delay.
- Evidence that lost or damaged personal property has actually been repaired or replaced.

Personal Liability Benefit claims:
- Incident/police reports, as available.
- Judgment or settlement assigning liability to the Policyholder/Participating Organization
- Receipts for any travel and accommodation expenses incurred for court attendance.

Personal Monetary Loss/Personal Property Loss Benefit claims:
- Supporting documentation of loss from bank, credit card issuer, mobile phone or mobile payment provider
- Initial report and claim submitted to the Common Carrier and any other insurer and the results of any settlement or denial of claim.
- Evidence that lost, stolen, or damaged personal property has actually been repaired or replaced.

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 Important Notice on page 4 of this form.

_____ _____

Signature of Claimant or Representative of Policyholder/Participating Organization Date

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

For residents of all states EXCEPT Arizona, Alabama, California, Colorado, Florida, Kentucky, Maine, Maryland, New Jersey, New York, Ohio, Oklahoma, 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 Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

For Residents of Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

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 information to obtain or amend insurance coverage or to make a 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, 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 Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit and who knowingly or willfully 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 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 Ohio: Any person who, with intent to defraud or knowing he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

For residents of Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

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 benefits 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 by 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 be 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.

For residents of Virginia: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

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.

The statements contained in this form are true and complete to the best of my knowledge and belief.

Signature _____ Date _____