Participant Accident
Statement of Claim for
Living Benefit Option

IMPORTANT INSTRUCTIONS FOR COMPLETING CLAIM FORM(S)

To the Policyholder and Claimant:

We know this is a difficult time, and we want to assist you in filing your claim as quickly as possible. Please read these important instructions regarding completion of these forms.

The information below constitutes a complete claim filed with The Hartford for purposes of claiming the Living Benefit Option under a Participant 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.

☐ If the Insured has designated a Beneficiary, attach a copy of the designation.

☐ If the Insured has designated an Irrevocable Beneficiary, attach a copy of this document, and indicate to the Insured that the Consent Form for Payment on page 7 should be completed by an Irrevocable Beneficiary and returned to The Hartford.

Part II – Claimant's Statement

☐ Page 3 of this form is to be completed in its entirety and signed by the insured who is claiming the Living Benefit Option.

☐ Read and sign the Important Notice on page 4, and read the Disclosure form on page 6.

☐ If you have designated an Irrevocable Beneficiary, please have your Irrevocable Beneficiary complete, sign, and date the Consent Form for Payment on page 7.

☐ Give the Attending Physician's Statement on page 5 to your physician and request that he/she completes the form and returns it to The Hartford.

Part III – Attending Physician's Statement

☐ Form is to be completed in its entirety and signed by the healthcare provider who is treating the Claimant.

☐ Sign and date the form on page 5.

Please note that this option may be exercised only once.

Submit claim by mail to: P.O. Box 189
Bridgton, ME 04009

For questions about how to complete this form, call NAHGA Toll-free at 1-888-998-2240 .

Phone number: 1-888-998-2240
Fax number: 1-207-647-4569
Email address: claims@nahga.com

Mail forms to: P.O. Box 189
Bridgton, ME 04009

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Email address: claims@nahga.com

PART I – POLICYHOLDER'S STATEMENT

(Please verify if the insured qualifies for any other group benefits through The Hartford and submit the claim accordingly)

Policy Number:	Policyholder Name:	
Policyholder Email Address:	Policyholder Phone Number: ( )	
Policyholder Address (Street, City, State, & Zip Code):		
Insured Name:	Insured Date of Birth:	Insured Social Security Number:
Insured Address (Street, City, State, & Zip Code):		
Date of Incident:	Time of Incident (hh:mm): ☐AM ☐PM	Place of Incident:
Nature of Injury(ies):		
Fully describe the circumstances of the Incident (Use a separate sheet of paper, if necessary):		

Is there a Beneficiary Designation on file? ☐ Yes ☐ No (If "Yes," attach a copy of designation.)

Has insured designated an irrevocable beneficiary? ☐ Yes ☐ No (If "Yes," the Insured should give the Irrevocable Beneficiary page 7 of this form, Consent Form for Payment of Living Benefit Option, for completion. Once completed, it should be attached to this form when the claim is submitted.)

POLICYHOLDER CERTIFICATION (SIGNATURE REQUIRED)

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

I further 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 Hartford and/or its representative.

Title of Policyholder Official	Signature of Policyholder Official	Date

NOTE: PLEASE BE SURE INSURED RECEIVES ALL 7 PAGES OF THIS FORM.

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PART II – CLAIMANT'S STATEMENT

Full Name of Insured:	Date of Birth:
Insured Address: (*Street, City, State, & Zip Code)*	
Nature of Injury(ies) and associated conditions:	
Amount of Living Benefit Option requested*: $ _____ *Note: **This option may be exercised only once.** The amount being requested may not exceed the percentage of the Insured's Principal Sum set forth in the Policy and is subject to the maximum amounts contained in the Policy. The Living Benefit Option may be taxable and may affect eligibility for public assistance. **We recommend you consult with your Tax Advisor with any questions.**	

Physicians who have treated your Injury(ies) and associated conditions (attach additional pages as needed)

Name of Healthcare Provider:	Treatment Dates: From: To:
Address: (*Street, City, State, & Zip Code)*	
Phone Number: ( )	Fax Number: ( )
Name of Healthcare Provider:	Treatment Dates: From: To:
Address: (*Street, City, State, & Zip Code)*	
Phone Number: ( )	Fax Number: ( )
Name of Healthcare Provider:	Treatment Dates: From: To:
Address: (*Street, City, State, & Zip Code)*	
Phone Number: ( )	Fax Number: ( )

I hereby certify that the information provided by me in this Statement of Claim form is true and complete to the best of my knowledge and belief, and that I have read and understand the statements on page 4 of this form. I hereby authorize any hospital or physician who has attended or examined me to disclose to The Hartford® or any of its representatives all information acquired by reason of, and records pertaining to, such hospitalization, examination and attendance. My consent is hereby granted to use this original form or a photocopy as equally valid authorization.

☐ I acknowledge that I have received and read the Disclosure Form on page 6 of this form. If there is an irrevocable beneficiary, page 7 is completed and attached.

_____ _____
Signature of Insured Date

_____
Signature of Witness

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 _____

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PART III – ATTENDING PHYSICIAN'S STATEMENT

Your patient has requested an advanced payment of benefits on his/her group accident insurance policy carried through The Hartford®. To qualify for this benefit, the patient must have sustained Injury(ies) that, with reasonable medical certainty, will result in the death of the insured in less than 12 months from the date of this statement. Your assistance is requested to help us determine your patient's eligibility.

Name of Patient:	Date of Birth:	Social Security Number:

What is the nature of the injury(ies) and associated conditions causing this patient to be terminally ill? Please provide the diagnosis and physical exam findings.

When did injury(ies) occur?	Date patient was informed of diagnosis:	First Treatment Date:	Last Treatment Date:

Frequency of treatment: ☐ Daily ☐ Weekly ☐ Monthly ☐ Other:

Has this injury(ies) affected the mental capacity of the patient? ☐ Yes ☐ No

If "Yes," is the patient still capable of managing his or her own affairs? ☐ Yes ☐ No

Has the patient ever had the same or similar condition? ☐ Yes ☐ No If "Yes," please state when: _____ and describe:

Will the patient's condition, with reasonable certainty, result in the patient's death within 12 months? ☐ Yes ☐ No

Name of Healthcare Provider:	Degree:	Specialty:

Address of Healthcare Provider *(Number, Street, City, State, & Zip Code):*

Telephone Number: ( )	Fax Number: ( )

Signature of Physician:	Date:

Should The Hartford require additional information, we will contact you.

IMPORTANT – READ CAREFULLY

DISCLOSURE FORM
LIVING BENEFIT OPTION

You have elected the Living Benefit Option under your Accidental Death insurance coverage offered through the Policyholder and underwritten by The Hartford®. As a result of electing this option, the total Principal Sum of your Accidental Death insurance coverage will be reduced by the amount of the Living Benefit Option. The effect of electing this option is to accelerate payment of a portion of your Accidental Death insurance proceeds.

EXAMPLE SITUATION:

An Insured Person has a $50,000 Principal Sum under a Participant Accident insurance policy. The Insured Person requests 50% of this Prinicpal Sum under the Living Benefit Option. This requested amount would equal $25,000 ($50,000 x 50% = $25,000). As a result of the accelerated payout, the Insured Person's Principal Sum will be reduced to $25,000 ($50,000 - $25,000 = $25,000).

AS A RESULT OF ELECTING THE LIVING BENEFIT OPTION, YOU SHOULD BE AWARE OF THE FOLLOWING:

1) Receipt of an accelerated benefit payment may adversely affect your right to receive certain public funds such as Medicare, Medicaid, Social Security, Supplemental Security Income and possibly others.

2) Receipt of an accelerated benefit payment may be taxable. See your personal tax advisor for further information.

3) Any accelerated benefit payments received are intended to qualify under Section 101 (g) (26 U.S.C. 101 (g)) of the Internal Revenue Code of 1986 as amended by Public Act 104-191.

RELEASE FROM ASSIGNMENT

If you have executed an assignment of interest with respect to your Principal Sum of Accidental Death insurance coverage, The Hartford® must receive a release from the individual to whom the assignment was made before any benefits are payable under the Living Benefit Option. The form required for this release, Consent Form for Payment of Living Benefit Option, is on page 7 of this form.

CONSENT FORM FOR PAYMENT OF LIVING BENEFIT OPTION

Policy Number:	Policyholder Name:
Insured Name:	

I, _____ the Irrevocable Beneficiary of the above-named

Policy, acknowledge that _____ has requested payment of a Living
Name of Insured

Benefit Option under his/her Certificate.

I hereby consent to the payment of a Living Benefit Option to _____.
Name of Insured

I understand that the payment of a Living Benefit Option reduces the amount of insurance payable on the death of

_____ by the amount of the Living Benefit Option paid.
Name of Insured

By executing this consent, I hereby release The Hartford® from any and all liability to the extent of the Living Benefit Option paid.

_____
Signature

_____
Date

Subscribed and sworn before me:

This _____ day of _____ , 20_____

_____
Notary Public