HARTFORD LIFE INSURANCE COMPANY
HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

Notice of Claim

FOR SPECIAL RISK, SPORTS, CAMPERS, YOUTH GROUPS & TRIPSTER POLICIES
The Hartford, P.O. Box 3856, Alpharetta, GA 30023 Toll Free (800) 678-6702 Fax (866) 954-3993

THE HARTFORD

POLICYHOLDER CERTIFICATION - To be completed by Policyholder Official

Policyholder Number	Policyholder Name

Policyholder Email Address	Policyholder Phone Number ( )

Policyholder Address (Street, City, State & Zip Code)

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 Government regulations, Medicare Beneficiary and Social Security Number information is required for all Claimants (including children & adults). Claims submitted with incomplete information will be returned.

Parent/Guardian completes for dependent child

Claimant (Dependent child) Name	Claimant Gender ☐ Male ☐ Female

*Is the Claimant a Medicare Beneficiary? ☐ Yes ☐ No
If yes, please provide Claimant's Social Security Number.

Claimant Date of Birth	Phone or Email Address

Claimant Address (Street, Apartment, 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.

Adult Claimant completes

Claimant Name	Claimant Gender ☐ Male ☐ Female

*Is the Claimant a Medicare Beneficiary? ☐ Yes ☐ No
If yes, please provide Claimant's Social Security Number.

Claimant Date of Birth	Phone or Email Address

Claimant Address (Street, Apartment, City, State, Zip)

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 _____