Group Life and Accidental Death Claim Forms for Employee or Dependent

IMPORTANT INSTRUCTIONS FOR COMPLETING CLAIM FORM(S)

To the Employer and Employee/Beneficiary, as applicable.

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. Also, please read the "Important Notice" on page 5.

The information below constitutes a complete claim filed with The Hartford for purposes of claiming Basic, Supplemental and Dependent coverage.

Part I - Employer's Statement (needed for both, Life or Accidental Death claims)

- ☐ Form is to be completed in its entirety and signed by the Official Representative of the Employer/Plan
- ☐ A certified copy of the Death Certificate stating cause and manner of death must be attached to this form..
- ☐ Proof of salary as defined in the Policy (attach W2 or commissions, if applicable)
- ☐ Submission of claims on any voluntary or contributory Life plans, including Dependent coverage, must include copies of the enrollment forms and history to show timely enrollment.
- ☐ All claims must be submitted, along with the beneficiary designation form(s) on file with the Employer/Plan, if any. If none on file, the Employer/Plan shall certify to that fact on the claim form.

Part II - Beneficiary Statement (needed for both, Life and Accidental Death claims)

- ☐ If more than one beneficiary, each beneficiary can either sign and date one form, or each can complete separate forms, showing their current address, date of birth and Social Security Number.
- ☐ **If claiming Accidental Death please furnish, if available, police or motor vehicle Accident/Incident reports, autopsy/ toxicology or other pertinent information regarding the claim.**

Miscellaneous - All Claims

- ☐ If the claim proceeds are payable to an Estate, Part II must be completed by the Executor or Administrator of the Estate. An official certificate of such person's legal appointment and qualification must be attached to this form. Please include the Estate Tax Identification Number. If none available, please explain.
- ☐ If any designated beneficiary is a minor, Part II must be completed by a custodian or guardian. Include the minor's social security number, also, please include a copy of the minor's birth certificate. An official certificate of the guardian's legal appointment and qualification of the minor's **estate or property** must also be included, if applicable.
- ☐ If claim is for a dependent child enrolled in an accredited school of higher learning, submitted documents should include a student enrollment verification form executed by the school, applicable if required under the Policy.
- ☐ Foreign Death - Include both the Official Death Certificate and the Death of American Citizen Abroad form.

Submit claim by mail to: The Hartford
Group Life Claims
P. O. Box 14299
Lexington, KY 40512-4299
Fax to: 1-866-954-2621
E-Mail to: gbclaimcslife@thehartford.com

Release of claim forms is not an admission of coverage under a policy for an employer, group or organization.

The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries.

All support services offered through Beneficiary Assist are provided by ComPsych®, a national leader in employee assistance programs. ComPsych is not affiliated with The Hartford. Neither The Hartford nor ComPsych® provide financial or legal advice.

HARTFORD LIFE INSURANCE COMPANY
HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

PROOF OF DEATH FORM (Group Life Insurance)
EMPLOYEE or DEPENDENT

Mail forms to: The Hartford
Group Life Claims
P. O. Box 14299
Lexington, KY 40512-4299
1-888-563-1124 Fax: 1-866-954-2621
E-Mail: gbclaimcslife@thehartford.com

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Clear Form

PART I - EMPLOYER STATEMENT - TO BE COMPLETED IN FULL FOR ALL CLAIMS
(Please verify if the employee qualifies for any other group benefits through The Hartford and submit the claim accordingly)

Group Policy Numbers:
Life/ AD&D: 870925 Voluntary AD&D:_____ Group Travel: _____

Employer:
Foulke Management Corp.

Name of Insured /Participant:

Social Security Number:

Insured's address: (Street, City, State & Zip Code)

Date of Birth:

Date of Death:

Branch/Location:

☐ Salaried ☐ Hourly

Date of Hire:

Effective date of employee's insurance:

Premiums paid to date? ☐ Yes ☐ No

Occupation:

Classification

Provide employee's actual date last physically at work: _____

Provide reason employee did not return to work on their next scheduled workday:
☐ Illness ☐ FMLA (provide approval form) ☐ Retirement - Date: _____ ☐ Other (please explain): _____

Is there a Beneficiary Designation Card on file? ☐ Yes ☐ No If "Yes," a copy must be submitted

AMOUNT OF INSURANCE BEING CLAIMED FOR EMPLOYEE OR AMOUNT IN FORCE FOR EMPLOYEE IF DEPENDENT CLAIM

Basic Life:
$

Supplemental Life:
$

Include AD&D amount(s) only if death was due to an accident

AD&D Basic:
$

AD&D Supplemental:
$

Coverage claimed above, reflect age reduction(s)? ☐ Yes ☐ No

Date insurance was discontinued or not in force _____

(Employee's earning as defined in the policy. Attach W-2 if applicable)

Rate of earnings used to calculate benefit amount: _____

☐ Hourly ☐ Weekly ☐ Monthly ☐ Annually

Regular hours scheduled to work: (if applicable) _____

Effective date of above reported earnings: _____

Do the earnings include commissions or bonuses? ☐ Yes ☐ No

Indicate if any of the following apply to this Employee:

☐ Applied for Conversion

☐ Has been approved for LBO/Accelerated Death Benefits by prior carrier

☐ Has been approved for Long Term Disability

☐ Has been approved for Waiver of Premium 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 on the effective date. Changes in amounts of coverage and increases are deferred until employee returns to active full-time work. If the employee elected increases in coverage during the past two years, the amount being claimed reflects the increase, attach copies of the election forms.

State name and amounts of other insurance policy(ies), if any.

DEPENDENT INFORMATION - ONLY COMPLETE FOR DEPENDENT CLAIM

Full Name of Deceased Dependent

Deceased's Social Security Number

Date of Birth

Date of Death

Relationship to Employee

Last Residence: (Number, Street, City or Town, Zip Code)

Is Employee Actively at Work? ☐ Yes ☐ No
If no, complete date last worked and reason above

Have premiums been paid to date for this dependent? ☐ Yes ☐ No

Was the dependent child, over the Policy's limiting age? ☐ Yes ☐ No

Was the dependent child a full-time student? ☐ Yes ☐ No If "Yes", and required by the Policy, include Enrollment verification from school.

Was dependent child incapacitated? ☐ Yes ☐ No

AMOUNT OF INSURANCE BEING CLAIMED FOR DEPENDENT

Basic Life:
$

Supplemental Life:
$

Include AD&D amount(s) only if death was due to an accident and applicable under the Policy

AD&D Basic:
$

AD&D Supplemental:
$

Dependent benefit is a: ☐ Flat Amount ☐ Percentage of Employee's amount
If a percentage, please complete amount of employee insurance above.

Does Coverage claimed reflect age reduction(s)? ☐ Yes ☐ No

Indicate if any of the following apply to this Dependent:
☐ Applied for Conversion
☐ Has been approved for LBO/Accelerated Death Benefits by prior carrier
☐ Has been approved for Waiver of Premium by prior carrier

Employer Certification: I hereby certify that the information provided on the Employer Statement 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 representative.

Foulke Management Corp.
Employer

Address

Signature

Date

Their Authorized Representative: (Please print)

( )
Telephone Number

E-mail address

( )
Facsimile Number

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PART II - Beneficiary's Statement

Name of Deceased: _____ **Policy Number(s):** 870925

Claim Number (if known): _____

Under penalties of perjury, I certify that:

(1) the number shown on this form is my correct taxpayer identification; and

(2) I am not subject to a back-up withholding, because, (a) I am exempt from back-up withholding; or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest and dividends; or (c) the IRS has notified me that I am no longer subject to back-up withholding; and

(3) I am a U.S. person (including a U.S. resident alien).

Certification Instructions: You must cross out item (2) above, if you have been notified by the IRS that you are currently subject to back-up withholding, because, you have failed to report all interest and dividends on your tax return.

By signing below:

(1) **I Hereby Certify and Agree** that I have read and understand the IMPORTANT NOTICE on page 5 of this claim form package.

(2) **I understand and Agree** that payment of the claim proceeds according to any alternate mode of settlement specified in the policy will only be made if the Company receives a written request for such alternate method of payment from me prior to the payment of the claim proceeds.

Beneficiary Name: (print)	Date of Birth:	Relationship:
Citizenship: ☐ U.S. citizen ☐ U.S. resident ☐ Non-resident alien (Request a W-8BEN)		
Complete Mailing Address: (Number & Street)	Beneficiary's Social Security Number or Estate /Trust Tax ID:	
(City, State & Zip Code)	Telephone Number: Day: ( ) Evening: ( )	
Personal Cell Telephone Number: (____)_____ May we have your authorization to leave confidential medical and benefit information on your personal cell phone? ☐ Yes ☐ No and/or request this by e-mail: ☐ Yes ☐ No Please initial:_____to confirm your election		
The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.		
Signature: **X**	Date:	E-mail address:

Beneficiary Name: (print)	Date of Birth:	Relationship:
Citizenship: ☐ U.S. citizen ☐ U.S. resident ☐ Non-resident alien (Request a W-8BEN)		
Complete Mailing Address: (Number & Street)	Beneficiary's Social Security Number or Estate /Trust Tax ID:	
(City, State & Zip Code)	Telephone Number: Day: ( ) Evening: ( )	
Personal Cell Telephone Number: (____)_____ May we have your authorization to leave confidential medical and benefit information on your personal cell phone? ☐ Yes ☐ No and/or request this by e-mail: ☐ Yes ☐ No Please initial:_____to confirm your election		
The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.		
Signature: **X**	Date:	E-mail address:

Beneficiary Name: (print)	Date of Birth:	Relationship:
Citizenship: ☐ U.S. citizen ☐ U.S. resident ☐ Non-resident alien (Request a W-8BEN)		
Complete Mailing Address: (Number & Street)	Beneficiary's Social Security Number or Estate /Trust Tax ID:	
(City, State & Zip Code)	Telephone Number: Day: ( ) Evening: ( )	
Personal Cell Telephone Number: (____)_____ May we have your authorization to leave confidential medical and benefit information on your personal cell phone? ☐ Yes ☐ No and/or request this by e-mail: ☐ Yes ☐ No Please initial:_____to confirm your election		
The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.		
Signature: **X**	Date:	E-mail address:

Group Life and/or Accidental Death Claim Form for EMPLOYEE or DEPENDENT

THE HARTFORD

Claimant's Statement of Accidental Death (complete only if death was due to an accident)

INSTRUCTIONS: Complete this form if you are applying for death benefits due to an Accident. If a question does not apply, please mark "N/A."

GROUP POLICYHOLDER/EMPLOYER NAME: Foulke Management Corp.

Name of Insured Employee/Participant:	**Social Security Number:**	**Policy Number(s):** Life 870925 AD&D 870925
Name of Deceased: (if different from above)	Age:	Relationship to Employee: ☐ Spouse ☐ Child

Has a Workers' Compensation claim been filed? ☐ Yes ☐ No If "Yes," what is the status of the claim? _____

On what date did the accident happen? _____ Where did the accident happen? City: _____ State: _____

Please describe injuries received:

Did accident result in death? ☐ Yes ☐ No If "Yes," on what date? _____

Describe in detail how the accident happened:

Name and address of law enforcement agency involved: *(Please submit copy of Police Accident Report and/or Case Number)*

List name/address/phone number of all physicians consulted for the injury/death:

List name/address/phone number of all hospitals consulted:

Did the deceased have any chronic disease or physical defect or deformity? ☐ Yes ☐ No If "Yes", describe in detail:

Was an autopsy performed? ☐ Yes ☐ No If "Yes," provide name/address/telephone number of coroner, if known:

Was an inquest held? ☐ Yes ☐ No If "Yes", verdict:

MEDICAL RELEASE AUTHORIZATION

To: Any health care provider, employer, benefit plan, insurer, service provider, financial institution, consumer reporting agency, educational institution, or Federal, State, or Local Government Agency, including the Social Security Administration and Veterans Administration. **I AUTHORIZE** you to disclose to The Hartford a complete copy of any and all of the following personal or privileged information, records, or documents relative to:

Insured's Name (Please print) _____ Date of Birth _____ Last 4 Digits of Social Security Number _____

Any and all medical information or records, including x-ray films, medical histories, physical, mental, or diagnostic examinations and treatment notes, and including information regarding HIV/AIDS, communicable diseases, alcohol or drug abuse, and mental health; work information and history, including job duties, earnings, personnel records, and client lists; information on any insurance coverage and claims filed, including all records and information related to such coverage and claims; credit information, including credit reports and credit applications; other financial information, including pension benefits and bank records; business transactions billing, invoice, and payment records; academic transcripts; and information concerning Social Security benefits, including monthly benefit amounts, monthly payment amounts, entitlement dates, and information from my Master Beneficiary Record. The information obtained by use of this Authorization will be used for the purpose of evaluating and administering my claim for benefits and/or leave request. Such information shall be referred to herein collectively as "My Information." I understand I have the right to revoke this Authorization for future disclosures, except to the extent action has been taken in reliance upon this Authorization. I must revoke this Authorization in writing directly to The Hartford.

I UNDERSTAND that information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient. I understand that I have the right to revoke this Authorization for future disclosures The Hartford may make,unless The Hartford has taken action in reliance upon this Authorization. I must revoke this Authorization in writing directly to The Hartford. I understand that my medical treatment or payment for medical benefits cannot be conditioned on my allowing The Hartford to re-disclose My Information. The authorizations set forth herein expire two years from the date listed below, or upon my revocation, if earlier, but will not exceed the term of my coverage under the policy(ies) or benefit plan or program, except as may be reasonably necessary to prevent or detect perpetration of a fraud or protect the personal safety of others. I understand that I am entitled to receive a copy of this Authorization upon request. A photocopyor facsimile of this Authorization shall be as valid as the original. If there is a conflict between a prior request for restrictionon the disclosure of My Information and this Authorization, this Authorization will control.

Signature of Beneficiary or Personal Representative _____ Date _____ Relationship to Insured _____

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, California, Colorado, Florida, Kentucky, Maine, Maryland, New Jersey, New York, 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 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 California: For your protection, California law requires the following to appear on this form: Any person who knowingly presents 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.

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, Virginia and Washington: It is a crime to knowingly provide false, incomplete or misleading information to 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 or 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 nformation 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 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.

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 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.

Signature _____ Date _____