HARTFORD LIFE INSURANCE COMPANY
HARTFORD FIRE INSURANCE COMPANY
HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

THE HARTFORD

NOTICE OF CLAIM – YOUTH GROUPS, SPECIAL RISK, SPORTS OR CAMPERS POLICIES

TO BE COMPLETED BY LEADER OR OTHER OFFICIAL

SECTION I

Policy Number	Policy Period	Name and Location of Agency	
Name of Organization			
Address of Organization			
Name of Member	Address	Date of Birth	Social Security No.
Date and Time of Accident	Place of Accident		
Nature of Injury	What caused the accident?		
Describe type of sport or activity engaged in at time of accident:			
Name of Supervisor of the activity			
Witness to accident (Name and address)			
Nature of illness		Date illness commenced	

I hereby certify that the above is a member of the group insured under Policy Number _____ and that the above described injury or sickness was sustained while participating in official activities under adequate supervision. If a scouting group, the member's date of registration with the Council is _____

TITLE OF OFFICIAL **SIGNATURE**

ADDRESS **DATE**

TO BE COMPLETED BY CLAIMANT

SECTION II

To whom are payments to be made? ☐ Claimant ☐ Doctor ☐ Hospital
Address:

Your Employer (if minor child, father's employer)	Address	Telephone Number
Are there Medical Benefits available from the above employer? ☐ Yes ☐ No		
Your Spouse's Employer (if minor child, mother's employer)	Address	Telephone Number
Are there Medical Benefits available from the above employer? ☐ Yes ☐ No		

If "Yes," and this policy is an excess policy, please include copies of explanation of benefits from the above employer's medical plans with your claim.

I hereby authorize any physician who has attended me or may attend me or any hospital where I may have been seen as a patient, or any other individual or association who may have given me medical treatment or supplies to disclose any information thus acquired. My consent is hereby granted to use this original or a photostatic copy as equally valid authorization.

Patient's signature — if claim is for other than minor child	Date
Signature of Parent — if claim is for minor	Date

ITEMIZED BILLS FOR HOSPITAL AND MEDICAL TREATMENT MUST BE ATTACHED HEREWITH.

Attending Physician Must Complete the Reverse Side of this Form.

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ATTENDING PHYSICIAN'S STATEMENT — HEALTH INSURANCE CLAIM — GROUP OR INDIVIDUAL

SECTION III

Patient's Name and Address	Age
Diagnosis and Concurrent Conditions (If Fracture or Dislocation, Describe Nature and Location)	
When did symptoms first appear or accident happen?	Date .....
When did patient first consult you for this condition?	Date .....
Has patient ever had same or similar condition? (If "Yes", state when and describe)	Yes ☐ No ☐
Nature of Surgical Procedure, if any. *(Describe Fully)*	Date Performed.....
Charge to patient for this procedure including post-operative care.	$ .....
If performed in hospital, give name of hospital.	Inpatient ☐ Outpatient ☐
Give dates of other medical (non-surgical) treatment, if any.	Charge Per Call Office.....$..... Home.....$..... Hospital.....$..... Nursing Home.....$..... Total (Non-Surgical) Charges $ .....
What other services, if any, did you provide patient? (Itemize Giving Dates and Fees)	
Were registered private duty nurse (R.N.) services necessary?	Yes ☐ No ☐
Is patient still under your care for this condition? If "No", give date your services terminated.	Yes ☐ No ☐ Date
How long was or will patient be continuously totally disabled *(Unable to work)*?	From .....Thru.....
How long was or will patient be partially disabled?	From .....Thru.....
Was house confinement necessary? If "Yes" give dates.	Yes ☐ No ☐ From .....Thru.....
To your knowledge does patient have other health insurance or health plan coverage? If "Yes" identify.	Yes ☐ No ☐
Is condition due to injury or sickness arising out of patient's employment? If "Yes" explain.	Yes ☐ No ☐

(ANSWER ALL QUESTIONS ABOVE, IN ADDITION TO THOSE BELOW, IF DENTISTRY)

State exactly which teeth were involved in the accident and indicate them on the chart:.....

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Describe exact nature of injury:.....

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	8	7	6	5	4	3	2	1		1	2	3	4	5	6	7	8
U	☐	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
				E	D	C	B	A		A	B	C	D	E			
				RIGHT					LINGUAL					LEFT			
				E	D	C	B	A		A	B	C	D	E			
L	☐	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
	8	7	6	5	4	3	2	1		1	2	3	4	5	6	7	8

Describe condition of teeth prior to accident:.....

.....

(State whether whole, sound and natural, filled, capped or artificial.)

REMARKS

Taxpayer Identification applicable to above charges. Social Security No. ☐☐☐–☐☐–☐☐☐☐ Employer Identification No. ☐☐–☐☐☐☐☐☐☐

Date | Signature (Attending Physician) | Degree | Telephone

Street Address | City or Town | State or Province | Zip Code