GROUP ACCIDENT, CRITICAL ILLNESS/SPECIFIED DISEASE & HOSPITAL INDEMNITY CLAIM FORM

Attending Physician/Medical Professional Statement (APS)

for Accident, Critical Illness/Specified Disease & Hospital Indemnity

Hartford Life and Accident Insurance Company

In furnishing this form, The Hartford® does not waive any of its rights or defenses nor admit liability. The Hartford® is The Hartford Financial Services Group, Inc., and its subsidiaries.

Employee/Member/Claimant Responsibilities:

1) If you are able to provide the appropriate supporting documentation to prove your claim (such as medical records, physician notes, ER/hospital discharge papers, radiology/pathology reports, itemized medical/hospital bills or medical EOBs), then this part of the form may not be required for the claim. If you are unable to provide the appropriate supporting documentation, as an alternative, you may ask your provider(s) to complete this form. You are responsible for any fees charged for proof requirements.
2) Complete the Employer/Policyholder & Employee/Member Information and Patient Information sections. For assistance, please call (866)547-4205.
3) Provide the form to the appropriate physician(s) or medical professional(s) for completion.

Physician/Medical Professional Responsibilities:

1) Complete the sections of the form applicable to the event/condition, then sign and date this form (near the bottom of page 2). For assistance, please call (866)547-4205. For a critical illness diagnosis, please also complete the Critical Illness/Specified Disease APS Supplement.
2) Provide all relevant supporting documentation such as medical statements/records, radiology/pathology reports, test/imaging results, hospital discharge summary, etc. The claimant is responsible for any fees charged for proof requirements.
3) Submit the form and required documentation to The Hartford Supplemental Insurance Benefit Department, PO Box 99906, Grapevine, TX 76099; or fax to (469) 417-1952.

EMPLOYER/POLICYHOLDER & EMPLOYEE/MEMBER INFORMATION (To be completed by the claimant)

Employer/Policyholder Name	**Policy Number**
CBIA Service Corporation	678208
Employee/Member Name (First MI Last)	**Last 4 Digits of SSN or Tax ID #**

PATIENT INFORMATION (To be completed by the claimant)

Patient Name (First MI Last)	**Date of Birth**	**SSN or Tax ID #**	**Gender** ☐ Male ☐ Female
Relationship to Employee/Member ☐ Self ☐ Spouse/Partner ☐ Child	**Nature of Illness/Injury/Diagnosis**		

EVENT INFORMATION* (To be completed by physician/medical professional)

Provide a description of the illness/injury and the primary diagnosis/ICD code(s): (For pregnancy, complete Pregnancy Info. section below)

☐ Check here if patient is deceased as a result of the illness/injury; Date of death:

List surgical or diagnostic procedure(s) for this condition (if any), including date, current CPT code(s) and facility:

Date Symptoms First Appeared or Accident/Injury Happened	**Date Patient First Consulted You for This Condition**
Date(s) of Treatment	**Is the patient still under your care?** ☐ No ☐ Yes; *If Yes, date of last treatment:*

Has the patient ever previously had the same or similar condition?
☐ Yes ☐ No ☐ Unknown; *If Yes, when and what:*

Describe any other disease or infirmity affecting the present condition:

Is the condition work related/arising out of the patient's employment?
☐ No ☐ Yes; *If Yes, explain:*

If condition is the result of an accident, are all injuries/services identified on this form a direct result of the accident?
☐ Yes ☐ No; *If No, explain:*

If condition is the result of an accident, was the patient under the influence of alcohol or drugs at the time of accident/injury?
☐ No ☐ Unknown ☐ Yes; *If Yes, explain:*

Was the patient confined to a hospital or rehabilitation facility? ☐ No ☐ Yes; *If Yes, complete Hospital/Rehab Facility section(s)*	**Was home health care prescribed or recommended to aid in recovery?** ☐ Yes ☐ No

Was a medical device/appliance, durable medical equipment or prosthetic device prescribed or recommended?
☐ No ☐ Yes; *If Yes, what:*

*If additional space is needed, please provide on a separate sheet of paper and submit with this form. Include the patient name and SSN/Tax ID#.

FORM CONTINUES ON NEXT PAGE

PREGNANCY INFORMATION – COMPLETE IF THE CLAIM IS THE RESULT OF A PREGNANCY

Date of Delivery/Expected Delivery Date	**Type of Delivery/Expected Type of Delivery** ☐ Vaginal ☐ Elective C-section ☐ Unplanned C-section	**First Day of Last Period**
Are/were there any complications of pregnancy? ☐ No ☐ Yes; Explain what and when:*		

*If additional space is needed, please provide on a separate sheet of paper and submit with this form. Include the patient name and SSN/Tax ID#.

HEALTH HISTORY INFORMATION*

Has the patient ever been treated for any heart condition, diabetes or cancer prior to this condition? ☐ No ☐ Unknown ☐ Yes; *If Yes, explain what and when:*
Please list conditions and corresponding dates for which you have treated this patient in the past five years, if any:

*If additional space is needed, please provide on a separate sheet of paper and submit with this form. Include the patient name and SSN/Tax ID#.

HOSPITAL INFORMATION – COMPLETE IF PATIENT WAS CONFINED DUE TO THE EVENT*

Hospital Name		**City**	**State**	**Zip**
Date of Admission	**Date of Discharge**	**Reason for Stay**		
Was the patient ever confined to the ICU (or equivalent) during this hospital stay? ☐ Yes** ☐ No	**If Yes, date ICU stay began:		**If Yes, date ICU stay ended:	

*If patient stayed at more than one hospital, please provide information on a separate sheet of paper and submit with this form. Include the patient name and SSN/Tax ID#.

REHABILITATION FACILITY INFORMATION – COMPLETE IF PATIENT WAS CONFINED DUE TO THE EVENT*

Rehabilitation Facility Name		**City**	**State**	**Zip**
Date of Admission	**Date of Discharge**	**Reason for Stay**		

*If patient stayed at more than one hospital, please provide information on a separate sheet of paper and submit with this form. Include the patient name and SSN/Tax ID#.

OTHER PHYSICIAN INFORMATION* – INCLUDE ALL OTHER KNOWN PHYSICIANS PROVIDING PATIENT CARE*

Physician Name		**Physician Name**		**Physician Name**	
Specialty		**Specialty**		**Specialty**	
Address (City, State & Zip)		**Address** (City, State & Zip)		**Address** (City, State & Zip)	
Phone #	**Fax #**	**Phone #**	**Fax #**	**Phone #**	**Fax #**

*If additional space is needed, please provide on a separate sheet of paper and submit with this form. Include the employee/member name, SSN/TAX ID# and policy number.

ADDITIONAL INFORMATION/REMARKS – USE THIS SPACE FOR ADDITIONAL INFORMATION, AS NEEDED

ATTENDING PHYSICIAN/MEDICAL PROFESSIONAL INFORMATION

Physician/Medical Professional Name		**License Number**	
Specialty	**EIN, Tax ID # or SSN**	**Phone Number**	**Fax Number**
Address (Street, City, State & Zip)		**E-mail Address**	
Are you related to or familiar with the patient? ☐ Yes ☐ No; *If Yes, explain relationship:*			

PHYSICIAN/MEDICAL PROFESSIONAL CERTIFICATION

I hereby certify that the information provided on this form is true and complete to the best of my knowledge and belief, and that I have read and understand the "Important Notice–Fraud Warning Statements" that applies to my state of residence.	
Physician/Medical Professional Signature	**Date of Signature**

END OF FORM – FOR CRITICAL ILLNESS CLAIMS, COMPLETE THE CRITICAL ILLNESS/SPECIFIED DISEASE APS SUPPLEMENT

GROUP ACCIDENT, CRITICAL ILLNESS/SPECIFIED DISEASE & HOSPITAL INDEMNITY CLAIM FORM

Attending Physician/Medical Professional Statement (APS) Critical Illness/Specified Disease Supplement

Hartford Life and Accident Insurance Company

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Physician/Medical Professional Responsibilities:

1) Complete the sections of the form applicable to the illness/condition, then sign and date this form. For assistance, please call (866)547-4205.
2) Provide all relevant supporting documentation such as medical statements/records, radiology/pathology reports, test/imaging results, etc. The claimant is responsible for any fees charged for proof requirements.
3) Submit the form and required documentation to The Hartford Supplemental Insurance Benefit Department, PO Box 99906, Grapevine, TX 76099; or fax to (469)417-1952.

PATIENT INFORMATION

Patient Name (First MI Last)	**Date of Birth**	**SSN or Tax ID #**	**Gender** ☐ Male ☐ Female

ILLNESS/CONDITION INFORMATION*

Please check the illness/condition(s) for which this claim is being filed and provide any relevant test results, pathology the reports, operative reports, hospital discharge summary and/or your detailed medical statement with this form, in addition to the information indicated below:

Illness/Condition	**Medical Documentation** (as applicable)	**Additional Information**
Cancer Conditions		
☐ Cancer	Pathology report, clinical diagnosis, surgical report	▪ TNM Stage: _____ ▪ Grade: _____ ▪ Is the patient HIV positive? ☐ Yes ☐ No
☐ Bone Marrow Transplant	Pathology report, clinical diagnosis, proof of listing with NMDP, surgical report	▪ What disease necessitated the transplant? _____ ▪ Is/was the transplant medically necessary? ☐ Yes ☐ No
☐ Benign Brain Tumor	MRI, CT, angiogram, pathology report, tumor biopsy, surgery report	▪ Size of tumor (in cm): _____ ▪ Location of tumor: _____ ▪ Is surgical removal medically necessary, or are there permanent neurological deficits as a result of the tumor? ☐ Yes ☐ No
Heart/Vascular Conditions		
☐ Heart Attack (Myocardial infarction)	EKG, cardiac enzymes, biochemical markers, thallium scans, MUGA scans, cardiac catheterization, echocardiogram, lab reports	▪ Are new/serial EKG findings consistent with MI? ☐ Yes ☐ No ▪ Were cardiac enzymes elevated above generally accepted lab levels of normal (CK-MB and/or troponins)? ☐ Yes ☐ No ▪ Did diagnostic studies confirm a MI and the occlusion of one or more coronary arteries? ☐ Yes ☐ No ▪ Did the MI occur during a clinical procedure? ☐ Yes ☐ No
☐ Coronary Artery Disease/Bypass	Angiogram, EKG, echocardiogram, stress test, EBCT, thallium test, surgical report	▪ Was there at least 70% blockage of one or more coronary arteries for which surgery was recommended? ☐ Yes ☐ No ▪ Did/will the patient undergo open heart surgery with bypass grafts? ☐ Yes ☐ No
☐ Angioplasty/Stent	Angiogram, EKG, echocardiogram, stress test, EBCT, thallium test, surgical report	▪ Is/was reconstitution/recanalization of the blood vessel(s) medically necessary? ☐ Yes ☐ No
☐ Stroke Note: Does not include TIA, head injury or chronic cerebrovascular insufficiency	Neuroimaging studies, documented neurological deficits	▪ Was diagnosis made with neuroimaging studies consistent with diagnosis of a new stroke? ☐ Yes ☐ No ▪ Is there evidence of persistent neurological deficits at least 30 days post CVA? ☐ Yes ☐ No ▪ mRS Level: _____
☐ Aneurysm	Angiogram, CT, MRI, echocardiogram, ultrasound, surgical report	▪ Is/was surgical repair of the blood vessel(s) medically necessary? ☐ Yes ☐ No
Organ Conditions		
☐ Major Organ Failure/Transplant	Proof of listing with UNOS (or equivalent), surgical report	▪ Did/will the patient undergo surgery to receive a human heart, liver, lung, kidney or pancreas? ☐ Yes ☐ No ▪ Does the patient have irreversible organ disease but is too ill to be on a transplant list? ☐ Yes ☐ No
☐ End Stage Renal Disease	Proof of regular hemodialysis or peritoneal dialysis, proof of listing with UNOS (or equivalent)	▪ Does the patient have permanent, irreversible failure to function of both kidneys? ☐ Yes ☐ No ▪ Does the patient require dialysis at least weekly? ☐ Yes ☐ No
☐ Acute Respiratory Distress Syndrome	Arterial blood gas, chest X-ray	▪ P/F Ratio: _____ ▪ OI: _____ ▪ PCWP: _____ ▪ Murray LIS: _____
Neurological/Nerve Conditions		
☐ Amyotrophic Lateral Sclerosis (ALS)	EMG, NCV, X-ray, MRI, blood/urine studies spinal tap, myelogram, muscle/nerve biopsy	▪ Is the condition "middle" stage or greater? ☐ Yes ☐ No ▪ Date of initial (first ever) diagnosis: _____

*If additional space is needed, please provide on a separate sheet of paper and submit with this form. Include the patient name and SSN/Tax ID#.

FORM CONTINUES ON NEXT PAGE

ILLNESS/CONDITION INFORMATION – CONTINUED*

Please check the illness/condition(s) for which this claim is being filed and provide any relevant test results, pathology the reports, operative reports, hospital discharge summary and/or your detailed medical statement with this form, in addition to the information indicated below:

Illness/Condition	Medical Documentation (as applicable)	Additional Information
Neurological/Nerve Conditions – Continued		
☐ Advanced Alzheimer's Disease	CT, MRI, PET, CSF, neurological exam	▪ FAST Stage: _____ ▪ MMSE Score: _____ ▪ Date of initial (first ever) diagnosis: _____
☐ Advanced Multiple Sclerosis	MRI, CSF, EP, neurological exam	▪ Has the condition produced at least 2 neurological abnormalities? ☐ Yes ☐ No ▪ Are lesions present at more than one site within the central nervous system? ☐ Yes ☐ No ▪ Date of initial (first ever) diagnosis: _____
☐ Advanced Parkinson's Disease	CT, MRI, PET, neurological exam, cognitive tests	▪ Stage: _____ ▪ Does the patient have permanent clinical impairment of motor function? ☐ Yes ☐ No ▪ Date of initial (first ever) diagnosis: _____
Child Conditions		
☐ Cerebral Palsy	Formal diagnosis after age of 18 months, MRI, CT, ultrasound, EEG	▪ Have all other similar conditions/disorders been ruled out? ☐ Yes ☐ No ▪ Date of initial (first ever) diagnosis: _____
☐ Congenital Heart Disease	EKG, echocardiogram, chest X-ray, cardiac catheterization	▪ Is open heart surgery medically necessary, or is the patient too ill to undergo surgery? ☐ Yes ☐ No ▪ Date of initial (first ever) diagnosis: _____
☐ Cystic Fibrosis	Genetic test, positive sweat test	▪ Date of initial (first ever) diagnosis: _____
☐ Muscular Dystrophy Note: Does not include SMA	Electromyography, muscle biopsy, blood tests, genetic tests	▪ Date of initial (first ever) diagnosis: _____
☐ Spina Bifida Note: Does not include SBO	Blood tests (MSAFP), ultrasound	▪ Date of initial (first ever) diagnosis: _____
Other Conditions		
☐ Coma Note: Does not include a medically induced coma	CT, MRI, EEG	▪ RLAS Level: _____ ▪ GCS Level: _____ ▪ Number of days of continuous unconsciousness: _____ ▪ Is the coma the result of an illness or disease, other than a stroke? ☐ Yes ☐ No ▪ Did the patient require mechanical ventilation for respiratory assistance while in the coma? ☐ Yes ☐ No
☐ Loss of Hearing	Audiological tests, documented evidence of the illness/disease that caused the loss	▪ Does the patient have irreversible hearing loss in both ears as the result of an illness or disease? ☐ Yes ☐ No ▪ Auditory threshold (in dB) while using a hearing aid: _____ ▪ Date of initial (first ever) diagnosis: _____
☐ Loss of Speech	Documented evidence of the illness/disease that caused the loss	▪ Does the patient have irreversible loss of the ability to speak as the result of an illness or disease? ☐ Yes ☐ No ▪ Has the loss of speech lasted for at least 12 mos.? ☐ Yes ☐ No ▪ Date of initial (first ever) diagnosis: _____
☐ Loss of Vision	Metric acuity, Snellen test, visual field test, documented evidence of the illness/disease that caused the loss	▪ Does the patient have irreversible loss of vision in both eyes as the result of an illness or disease? ☐ Yes ☐ No ▪ Is the best corrected visual acuity less than or equal to 20/200 in both eyes? ☐ Yes ☐ No ▪ Is the field of vision less than 20° in both eyes? ☐ Yes ☐ No ▪ Date of initial (first ever) diagnosis: _____
☐ Occupational HIV, Hep B or Hep C	HIV tests, Hep tests	▪ Was HIV/Hep testing conducted prior to and within 48 hours after the occupational exposure? ☐ Yes ☐ No ▪ If Yes, were the results negative? ☐ Yes ☐ No ▪ Subsequent to the initial post exposure test, did the patient test positive within 26 weeks of exposure? ☐ Yes ☐ No
☐ Paralysis	Documented evidence of the illness/disease that caused the paralysis	▪ Does the patient have complete and permanent loss of function of 2 or more limbs due to an illness or disease, other than stroke? ☐ Yes ☐ No ▪ Date of initial (first ever) diagnosis: _____

PHYSICIAN/MEDICAL PROFESSIONAL CERTIFICATION

I hereby certify that the information provided on this form is true and complete to the best of my knowledge and belief, and that I have read and understand the "Important Notice–Fraud Warning Statements" that applies to my state of residence.

Physician/Medical Professional Signature	Date of Signature

END OF FORM

GROUP ACCIDENT, CRITICAL ILLNESS/SPECIFIED DISEASE & HOSPITAL INDEMNITY CLAIM FORM

Important Notice – Fraud Warning Statements

Hartford Life and Accident Insurance Company

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

Please read the statement that applies to your state of residence prior to signing the claim form and prior to signing this form.

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 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 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 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 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 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 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 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.

Signature	**Date of Signature**