Clear Form

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

THE HARTFORD

NOTICE OF CLAIM - FOR VOLUNTEER FIREFIGHTER ACCIDENT MEDICAL & DISABILITY BENEFITS

A claim is being filed for: ☐ Medical Benefits ☐ Disability Benefits ☐ Medical and Disability Benefits

Send claims to: Chesterfield Insurers, Inc.
P. O. Box 34220, Richmond, VA 23234
Phone (804) 271-9426 Fax (804) 271-9108

Claim Instructions: The Policyholder should: Complete and sign Sections I and III
The Claimant should: Complete and sign Sections II, III, IV and V-A
The Attending Physician should: Complete and sign Section V-B

Section I - Policyholder Information - To be completed by Fire Commanding Officer

Policyholder Name		Policyholder Number
Policyholder Address		Commanding Officer's Phone Number ( )
Claimant (Injured Party) Name	Claimant Date of Birth	Claimant Social Security Number
Claimant Insured Person Status ☐ Volunteer ☐ Junior Fire Fighter ☐ Fire Fighter Auxiliary		
Claimant Address (Street, City, State and Zip Code)		Claimant Phone Number ( )
Date of Accident _____ mm/dd/yyyy	Time of Acident _____ hh:mm ☐ AM ☐ PM	Place of Accident
Complete description of Accident		
Indicate injured body part(s)		
Nature of Sickness (if applicable)		Date Sickness first commenced

Note - Please also include a copy of the Incident Report (if available)

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.

Title of Commanding Officer _____ Signature of Commanding Officer _____ Date _____

Section II - Claimant Information - To be completed by Claimant

- *If filing a claim for Medical Benefits:* Submit itemized medical bills to address referenced above and sign the Claimant Certification statement listed below.

Claimant Certification Signature Required:
I hereby certify the above information to be true and accurate to the best of my knowledge.

Signature of Claimant _____ Date _____

Section II - (Continued) Claimant Information

- *If filing a claim for Disability Benefits:* Fully complete all items in this section and submit to address referenced on page 1

Normal Occupation	Normal Occupation Work Hours	Name of Normal Occupation Employer	
Address of Normal Occupation Employer		Contact Phone Number ( )	Contact Fax Number ( )
Contact Name for Normal Occupation Employer		Exact duties unable to perform - Normal occupation	
Date last worked - Normal Occupation Employer		Date returned to work - Normal Occupation Employer ☐ Full Duty ☐ Light Duty _____	
Verification of Earnings (Submit Normal Occupation pay stubs for the last 3 months. If self-employed, send copy of your prior year's tax return)			
Attending Physician's Name	Attending Physician's Address		
Attending Physician's Phone Number ( )		Attending Physician's Fax Number ( )	
Do you have disability (loss of wages) coverage? (Check all that apply) ☐ Regular Occupation Policy ☐ Worker's Compensation ☐ Other _____			

Claimant Certification Signature Required:

I hereby certify the above information to be true and accurate to the best of my knowledge.

_____ _____

Signature of Claimant Date

Section III - Fraud Warning Statement - To be signed by Policyholder and Claimant (Based on State of residence)

For residents of Alaska, Arizona, Arkansas, Colorado, Connecticut, Delaware, D.C., Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Washington, West Virginia and Wisconsin: 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 subjects such person to criminal and civil penalties.

For residents of Alabama, Hawaii, Oregon, Vermont, Virginia, and Wyoming**:** 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 insurance benefits and may be subject to any civil penalties available.

For residents of California, California law requires the following: 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 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.

I hereby certify the foregoing statements made by me on this form to be true to the best of my knowledge. I am aware that if any of the foregoing statements on this form made by me are willfully false, I may be subject to penalties, which may include criminal prosecution.

_____ _____

Signature of Policyholder (Commanding Officer) Date

_____ _____

Signature of Claimant Date

Authorization to Obtain and Release Information

TO: Any physician, medical practitioner, hospital, pharmacy, clinic or other medical or medically-related facility or provider of medical or dental services or supplies;

Any employer, group policyholder, contract holder or insurer, benefit plan administrator, The Index System, business entities, financial institutions, consumer reporting agencies, educational institutions, or

Any Federal, State or Local Government Agency, including Social Security and Veterans Administration.

I authorize you to release and send to: (i) Hartford Fire Insurance Company, Hartford Life Insurance Company, Hartford Life & Accident Insurance Company, and any affiliates of these three companies, known collectively as The Hartford, or (ii) The Hartford's representatives, a complete copy of any and all of the following information, records or documents relative to:

Claimant's Name (Please Print)	Date of Birth	Social Security Number

1. Any and all medical information, including x-ray films, photocopies of medical records, medical histories, physical, mental or diagnostic examinations, and treatment notes. For purposes of this authorization, medical information specifically includes confidential information regarding HIV and AIDS, communicable diseases, alcohol or drug abuse, and mental health, as such information may relate to my claim for benefits.

2. Work information and history, including, but not limited to, job duties, earnings and personnel records, client lists, any and all other work-related information for contractual work performed; information on any insurance coverage and claims filed, including all records and information related to such coverage and claims: credit information, including, but not limited to, credit reports and credit applications; other financial information, e.g., bank records: business transactions of any kind or description, including billing, invoices or payment records of any kind: and academic transcripts.

3. Information concerning Social Security benefits, including, but not limited to, monthly benefit amounts, monthly payment amounts, entitlement dates, and information from my Master Beneficiary Record.

I understand that the information obtained by use of the Authorization will be used for the purpose of evaluating and administering a claim for benefits. Any information obtained will not be released by The Hartford to any person or organization EXCEPT to reinsuring companies or their representatives, The Index System, physicians who have treated me, or other persons or organizations performing business or legal services in connection with my Claim, or as may be otherwise lawfully required, or as I may further authorize, or as may be necessary to prevent or to detect the perpetration of a fraud.

I know that I may request to receive a copy of this Authorization.

This Authorization is given in connection with a claim for benefits. I intend that it be valid for the duration of the claim.

A photocopy or facsimile of this authorization shall be valid as the original.

Signature of Claimant	Date

Section V - Claimant Release & Attending Physician's Statement for Medical & Disability Services

(The patient is responsible for the completion of this form without expense to Company)

Section V- A Claimant Release - To be completed by the Claimant

Name of Claimant (Patient)	Social Security Number	Date of Birth

Address of Claimant (Street, City, State & Zip Code)

Name of Policyholder	Policy Number

I hereby authorize my Physician to release medical information for the purpose of processing my claim. A detailed Authorization can be found on the reverse side of this form.

Signed *(Patient)* _____ *Date* _____

Section V- B Attending Physician's Statement - To be completed by Attending Physician

Claimant Name	Social Security Number	Date of Birth

Diagnosis and Concurrent Conditions (ICD-9 code) - If fracture or dislocation, describe nature and location

Is treatment due to? ☐ Sickness ☐ Accident

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? ☐ Yes ☐ No If "Yes," state when and describe Date _____

Nature of surgical procedure, if any, (describe fully) performed CPT Code _____

Is patient still under your care for this condition? ☐ Yes ☐ No Date: _____

Did you refer patient to another physician? ☐ Yes ☐ No

If "Yes", Name, address, telephone number _____

How long was or will patient be continuously unable to work at **Normal Occupation*?** **From** _____ **Thru** _____

How long was or will patient be able to perform some but not all duties of his **Normal Occupation***? **From** _____ **Thru** _____

***LIMITATION (If there is a limitation, check**

☐ Standing ☐ Climbing ☐ Bending ☐ Use of Hands ☐ Sitting

☐ Walking ☐ Stooping ☐ Lifting ☐ Psychological ☐ Other *(State which)*

To your knowledge does patient have other health Insurance or health plan coverages? ☐ Yes ☐ No

If "Yes", identify

Attending Physician's Name: (Please print or type)	Telephone Number ( )
License Number	Fax Number ( )

Address (Street, City, State & Zip Code)

SS# or E.I.N.#	Degree	Specialty

Signature _____ Date Signed _____