HARTFORD LIFE INSURANCE COMPANY

CLAIM FORM FOR CANCER, SPECIFIED DISEASE & INTENSIVE CARE COVERAGE

FOR PROMPT CONSIDERATION, PLEASE ATTACH ALL ITEMIZED BILLS FROM ALL PROVIDERS AND ANY PATHOLOGY REPORTS

CLAIM FOR:

☐ CANCER ☐ SPECIFIED DISEASE ☐ INTENSIVE CARE ☐ WELLNESS BENEFIT

INSURED NAME		ADDRESS (CITY,STATE,ZIP)	
DATE OF BIRTH	SOCIAL SECURITY NO.	TELEPHONE NO.	POLICY NUMBER
PATIENT NAME	DATE OF BIRTH		SOCIAL SECURITY NO.

1. Describe your illness or injury: _____

   _____

   How did the injury occur: _____

   If an *injury*, the date of occurrence: _____ If an *illness*, the date you *first* noticed symptoms: _____

2. Name and address of the *first* physician you consulted for this condition? _____

   _____ Date consulted: _____

3. Date, if ever, that you had similar or same condition before: _____

4. If you were confined to a hospital, the hospital's name and address: _____

   _____

   Date admitted: _____ Date discharged: _____

5. List All Physicians Consulted in the Last Five Years:

   Name of Doctor Address Telephone # Date

   _____

   _____

   _____

   _____

Notice to all claimants: Any person who, with 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, is guilty of insurance fraud.

You are hereby authorized to permit the Hartford Life Insurance Company, National Plan Administrators, Inc. and its authorized representatives to view and obtain a copy of ALL RECORDS as to examination, history, diagnosis, treatment and prognosis with respect to any physical or mental condition including psychiatric, drug, or alcohol treatment and disease. I agree a photographic copy of this authorization shall be valid as the original for two years.

Date _____ 19 _____ Signed (patient, or parent if minor) _____

If someone other than patient executed this form and authorization, indicate reason: _____

_____

Relationship to Patient: _____ Address: _____

_____

MAIL TO:

NATIONAL PLAN ADMINISTRATORS, INC.
P.O. BOX 161630
AUSTIN, TEXAS 78716

H-1300

Hartford Life

HARTFORD LIFE INSURANCE COMPANY

CLAIM FORM FOR WELL CARE BENEFIT

For prompt consideration, please attach all itemized bills from all providers and any pathology reports

CLAIM FOR: ☐ **Well Care Benefit**

INSURED NAME		ADDRESS (CITY, STATE, ZIP)	
DATE OF BIRTH	SOCIAL SECURITY NO.	TELEPHONE NO. ( )	POLICY NUMBER
PATIENT NAME		DATE OF BIRTH	SOCIAL SECURITY NO.

WELL CARE BENEFIT - Please attach a copy of your bill to this form.

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You are hereby authorized to permit the Hartford Life Insurance Company, National Plan Administrators, Inc. and its authorized representatives to view and obtain a copy of ALL RECORDS as to examination, history, diagnosis, treatment and prognosis with respect to any physical or mental condition including psychiatric, drug or alcohol treatment and disease. I agree a photographic copy of this authorization shall be valid as the original for two years.

Date_____20_____ Signed (patient, or parent if minor)_____

If someone other than patient executed this form and authorization, indicate reason, give your relationship to patient and address in full:

_____

Relationship to Patient:_____

Address:_____

_____

Mail To:

NPA
NATIONAL PLAN ADMINISTRATORS

National Plan Administrators, Inc.
P.O. Box 161630
Austin, Texas 78716