Participant Accident Statement of Claim for Disability Benefits

THE HARTFORD

IMPORTANT INSTRUCTIONS FOR COMPLETING CLAIM FORM(S)

To the Policyholder and Claimant:

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.

The information below constitutes a complete claim filed with The Hartford for purposes of claiming Participant Accident Disability benefits.

Part I – Policyholder's Statement

- ☐ Form is to be completed in its entirety and signed by the Official Representative of the Policyholder/Plan.
- ☐ Provide any necessary attachments (see Section D).

Part II – Employer's Statement

- ☐ Form is to be completed in its entirety and signed by the Official Representative of the Insured's Employer.
- ☐ Provide any necessary attachments (see Section G).

Part III – Claimant's Statement

- ☐ Form is to be completed in its entirety and signed by the insured who is claiming Disability benefits.
- ☐ Sign the Authorization to Obtain and Disclose Information, page 10 and 11.
- ☐ Provide a copy of the insured's driver's license.

Part IV – Attending Physician's Statement

- ☐ Form is to be completed in its entirety and signed by the healthcare provider who is treating the Claimant.
- ☐ Sign and date the form on page 13.
- ☐ Provide office visit notes, test results, etc. for the period the Claimant has been treated for the disabling condition.

Submit claim by mail to: P. O. Box 34220
Richmond, VA 23234

Phone number: 1-804-271-9426
Fax number: 1-804-271-9108
Email address: jennifer@chesterfieldinsurers.

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

Please verify if the insured qualifies for any other group benefits through The Hartford and submit the claim accordingly.

PLEASE SEE THAT ALL SECTIONS ARE FULLY COMPLETED AND SIGNED.

Clear Form

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Statement of Claim for Disability Benefits

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PART I - POLICYHOLDER'S STATEMENT - To be completed by the Official Representative of the Policyholder/Plan

A. Information About the Policyholder

Policy Number:	Policyholder Name:	
Policyholder Email Address:	Policyholder Telephone Number: ( )	Policyholder Fax Number: ( )
Policyholder Address (Street, City, State, & Zip Code):		
Participating Organization (or "n/a" if this does not apply):	Class (or "n/a" if this does not apply):	

B. Information About the Claimant

Claimant Name:	Claimant DOB:	Claimant Social Security Number:
Claimant Address (Street, City, State, & Zip Code):		Claimant Telephone Number: ( )

C. Information About the Claim

Benefits claimed for Disability due to:
☐ Accidental Injury ☐ Contagious and Infectious Disease ☐ Influenza ☐ Heart or Circulatory Malfunction

Nature of injury(ies) (if applicable):	Nature of sickness (if applicable):	
Date of Accident/Onset:	Time of Accident/Onset (hh:mm): ☐ AM ☐ PM	Place of Accident/Onset of Symptoms:
Fully describe the circumstances of the Accident/Onset of Symptoms (Use a separate sheet of paper, if necessary):		

D. Required Attachments and Signature

Please attach copies of the following documents as applicable:
- Medical information from the Claimant's file relating to this disability, if available.
- Incident/police reports relating to the incident.

I hearby certify the Insured is a member of the group insured under the above Policy and the loss was sustained under adequate supervision while participating in an official Covered Activity.

I further certify that the information provided on the Policyholder's Statement is true and complete according to the records of the Policyholder. I agree that this information is subject to audit by The Hartford and/or its representative.

Title of Policyholder Official	Signature of Policyholder Official	Date

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PART II - EMPLOYER'S STATEMENT - To be completed by the Official Representative of the Claimant's Employer

A. Information About the Employer

Employer Name:		
Employer Email Address:	Employer Telephone Number: ( )	Employer Fax Number: ( )
Employer Address (Street, City, State, & Zip Code):		
Branch/Location (or "n/a" if this does not apply):	Class (or "n/a" if this does not apply):	

B. Information About the Claimant

Claimant Name:	Claimant DOB:	Claimant Social Security Number:
Claimant Address (Street, City, State, & Zip Code):		Claimant Telephone Number: ( )
Date of Hire:	Occupation/Job Title:	Date Last Worked:

C. Information About the Claimant's Salary

Basic Salary or wage immediately prior to cessation of work because of disability: (exclude bonuses, overtime pay, etc.)
$ ☐ Annually ☐ Monthly ☐ Bi-Weekly ☐ Weekly ☐ Hourly

Is this Claimant receiving salary continuation? ☐ Yes ☐ No If "Yes," what is the weekly amount? $_____ Start Date: End Date:	Is the Claimant receiving Sick Pay? ☐ Yes ☐ No If "Yes," what is the weekly amount? $_____ Start Date: End Date:

D. Information About Other Benefits

Do you have a pension plan? ☐ Yes ☐ No If "Yes," what type? (Check as many as applicable)
☐ Defined contribution ☐ Profit Sharing ☐ 401 K ☐ Other (specify) _____

Is the Claimant eligible for your pension plan? ☐ Yes ☐ No If "No," why?	If eligible, does the Claimant participate? ☐ Yes ☐ No If "No," why?

If the Claimant is participating, when is he or she eligible for benefits under the plan? _____

At what point does the Claimant qualify for a full pension? _____	Is there a Disability Retirement Option available to this Claimant? ☐ Yes ☐ No
Has a claim been filed with Workers' Compensation? ☐ Yes ☐ No	Name and address of your compensation carrier
Is the Claimant receiving Short/Long Term Disability benefits? ☐ Yes ☐ No If "Yes," weekly amount? $ _____ Start Date: End Date:	Is the Claimant receiving State Disability benefits? ☐ Yes ☐ No If "Yes," weekly amount? $ _____ Start Date: End Date:

List any other sources of income to which the employee is entitled as a result of this disability:

E. Information About the Physical Aspects of the Claimant's Job

Check the items below that relate to the claimant's job and complete the information requested.
Select either majority of workday or sporadically.

Activity	Majority of workday (with standard breaks)		Sporadically throughout day	If sporadically circle time for each section below: Hours at one time	Total hours/8 hour
Sit	☐	or	☐	1 2 3 4 5 6 7 8	1 2 3 4 5 6 7 8
Stand	☐	or	☐	1 2 3 4 5 6 7 8	1 2 3 4 5 6 7 8
Walk	☐	or	☐	1 2 3 4 5 6 7 8	1 2 3 4 5 6 7 8

Can the job be performed alternating sitting and standing? ☐ Yes ☐ No

Activity	Never	Occasionally (1-33%)	Frequently (34-67%)	Constantly (68-100%)
Driving	☐	☐	☐	☐
Balancing	☐	☐	☐	☐
Bending at Waist	☐	☐	☐	☐
Kneeling/Crouching	☐	☐	☐	☐
Crawling	☐	☐	☐	☐
Climbing	☐	☐	☐	☐

Lift/Carry/Push/Pull: Task Description (Describe object moved and any mechanical assistance in the last column)					
Lifting		lbs.	lbs.	lbs.	
Carrying		lbs.	lbs.	lbs.	
Pushing/Pulling		lbs.	lbs.	lbs.	
Upper Extremity Activity (not load bearing) Specify right (R) or left (L) if not bilateral)					**Describe task performed**
Fine manipulation (fingering, keyboard)	☐	☐	☐	☐	
Gross manipulation (grip/grasp, handle)	☐	☐	☐	☐	
Reach (extend arms) above shoulder	☐	☐	☐	☐	
Reach (extend arms) below shoulder at desk or workbench level	☐	☐	☐	☐	

F. Information About the Job as it Relates to the Disability

Can the job be modified to accommodate the disability either temporarily or permanently? ☐ Yes ☐ No If "Yes," explain:

Is it possible to offer the claimant assistance in doing the job? (e.g., through the use of technology or personal assistance)
☐ Yes ☐ No If "Yes," explain:

Does your company have a rehire or return-to-work policy for disabled employees? ☐ Yes ☐ No

Name, title, and number of the manager we should contact if we identify a rehabilitation or return to work option for the Claimant:

G. Required Attachments and Signature

Please attach copies of the following documents as applicable:

- Job description detailing the essential duties and physical demands of the Claimant's job on the date they last worked
- If salary is based on a W-2, K-1, 1099 or similar document, attach a copy of the document

I certify information provided on the Employer's Statement is true and complete according to the records of the employer.

Title of Policyholder Official	Signature of Policyholder Official	Date

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PART III - CLAIMANT'S STATEMENT - To be completed by the Claimant (BE SURE TO ANSWER ALL QUESTIONS)

A. Information about you

Last Name: First Name: Middle Initial: | Date of Birth: | Social Security Number:

Address: (Street, City, State & Zip Code) | Gender: ☐ Male ☐ Female

Phone Numbers:
Daytime: (____)_____ Evening: (____)_____ Personal Cell Phone: (____)_____
E-mail Address:_____
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

_____ _____
Signature Date

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed | Your employer: (include division, if applicable) | Occupation:

Please indicate the extent of your formal education: (Check one)

☐ HS/GED ☐ Trade School/Certification Program ☐ AA/AS ☐ BA/BS ☐ Masters ☐ Doctorate ☐ Some college

☐ Other (please specify):_____

List all licenses, certifications, majors:_____

Have you served in the military? ☐ Yes ☐ No

Briefly describe your past work experience for the last 20 years (Begin with your most recent job.)

Dates Employed	Employer	Job Title	Duties

Now, or at some time in the future, would you be interested in seeking rehabilitation to some other kind of work? ☐ Yes ☐ No

Have you contacted your State Department of Vocational Rehabilitation? ☐ Yes ☐ No If "Yes," please include the name, address and telephone number of your counselor.

B. Information About your Family (required to determine your eligibility for Social Security Benefits)

Legal Spouse's Name: (Last, First)

Legal Spouse's Social Security Number: | Date of Birth: (Month/Day/Year) | Is your legal spouse employed? ☐ Yes ☐ No | Retired? ☐ Yes ☐ No

Do you have any children under Age 19? ☐ Yes ☐ No If "Yes," please provide the information requested below for each child.

Name:_____ Date of Birth:_____ Social Security Number:_____
Name:_____ Date of Birth:_____ Social Security Number:_____
Name:_____ Date of Birth:_____ Social Security Number:_____

Do you have any children with disabilities (regardless of age)? ☐ Yes ☐ No If "Yes," please provide the information requested below for each child

Name:_____ Date of Birth:_____ Social Security Number:_____
Name:_____ Date of Birth:_____ Social Security Number:_____
Name:_____ Date of Birth:_____ Social Security Number:_____

C. Information About the Condition Causing Your Disability

1. For illness, answer the following questions:

What were your first symptoms?

When did you first notice them?

Have you had this illness before? ☐ Yes ☐ No

If so, when?

2. For an injury, answer the following questions:

When, where and how did the injury occur?

Name and address of law enforcement agency involved and Case Number (if applicable):

3. For illness or injury, answer the following questions:

Next to any Activity of Daily Living (ADL), please place the number shown next to the statement that most accurately reflects your ability/inability to perform each: 1 = I can perform this activity independently; 2 = I can perform this activity with the use of equipment or adaptive devices; 3 = I cannot perform this activity.

( ) Bathe (tub, shower, or sponge)
( ) Dress
( ) Toilet
( ) Transfer from Bed to Chair
( ) Voluntary bladder and bowel control or ability to maintain a reasonable level of personal hygiene.
( ) Feed yourself with food that has been prepared and made available to you.

If you indicated **(3)** for any of the above activities, please describe the impairment and restrictions to your functionality that preclude you from performing this activity.

Height: _____ **Weight:** _____

Have you suffered a severe Cognitive Impairment that renders you unable to perform common tasks, such as using the phone, money management, or medication management? ☐ Yes ☐ No If "Yes," describe:

Date you were first treated by a Healthcare Provider? _____ (Month/Day/Year)

Name of Healthcare Provider:

Address of Healthcare Provider:

What aspect of your condition made you unable to work?

D. Information About the Disability

Last day you worked before the disability: _____ (Month/Day/Year)

Since that date, have you done any work? ☐ Yes ☐ No

If "Yes," please indicate dates worked, name of employer, and amount earned.

Date you were first unable to work: _____ (Month/Day/Year)

If you have not returned to work, do you expect to? ☐ Yes ☐ No

Part time _____ (date)

Full time _____ (date)

E. Information About Healthcare Providers and Hospitals

First medical attention for the current disability was given by (complete below)

Healthcare Provider's Name:

Telephone: ( )
Fax: ( )

Specialty:

Address: (Street, City, State & Zip)

Dates seen:
to

List all Healthcare Providers and Hospitals you have seen for this condition (attach separate sheet, if needed)

Healthcare Provider's Name:

Telephone: ( )
Fax: ( )

Specialty:

Address: (Street, City, State & Zip)

Dates seen:
to

Hospital:

Address: (Street, City, State & Zip)

Dates of Confinement:
to

F. Other Income

Check the other income benefits you have received/are receiving, or are eligible to receive during your disability (complete the information requested).

Source of Income	Amount (week /month)	Date Claim was filed	Date Payments began	Date Payments ended
Social Security: Disability/Retirement	$ _____ / _____			
Social Security: Widow's/Widower's	$ _____ / _____			
Sick Pay or Salary continuation	$_____ / _____			
Income from Work	$_____ / _____			
Workers' Compensation	$_____ / _____			
State Disability	$_____ / _____			
Pension: Disability/Retirement	$_____ / _____			
Public Employee/State Teacher: Retirement/Disability	$_____ / _____			
Short Term Disability	$_____ / _____			
Unemployment	$_____ / _____			
No-Fault Insurance	$_____ / _____			
Other (include individual Group Benefits or Veteran's Benefits)	$_____ / _____			

Are you paying for Medicare Part D? ☐ **Yes** ☐ **No** **If "Yes," please enter amount: _____. 00.**

G. Information about Tax Withholding

Federal law requires us to withhold federal income tax from your check if you request us to do so. We are also required to send a report to your policyholder at the end of each calendar year showing your name, total amount of benefits paid to you, total amount withheld, if any, and your Social Security Number. If you want us to withhold tax, please indicate on the line below the dollar amount to be withheld per week. Whole dollars only (minimum is $20.00 per week): $_____**.00 per week. IMPORTANT:** If your disability benefit is not taxable, you will not be able to request any federal income tax withholding from your check. Puerto Rico residents may not request withholding.

Note to residents of Iowa and the District of Columbia: Should you choose federal income tax withholding, your state requires us to withhold state income tax. We must withhold at a state mandated rate (which may be higher than you need) until we receive a signed state Tax Withholding Certificate from you. Please contact your State Tax Department to obtain the proper withholding form.

Note to residents of Nebraska, Rhode Island, and South Carolina: Should you choose federal income tax withholding, your state requires us to withhold state income tax. We must withhold at a state mandated rate (which may be higher than you need) until we receive a signed federal Form W-4, Employee's Withholding Allowance Certificate, from you. You may go to www.irs.gov to obtain the proper withholding form.

Signature - Please read the statement that applies to your state of residence and sign the bottom of the second page.

With the exception of any source(s) of income reported above in this form, I certify by my signature that I have not received and am not eligible to receive any source of income, except for my disability benefits from this plan. Further, I understand that should I receive income of any kind or perform work of any kind during any period The Hartford has approved my disability claim, I must report all details to The Hartford, immediately. If I receive disability income benefits greater than those which should have been paid, I understand that I will be required to provide a lump sum repayment to the Plan. The Hartford has the option to reduce or eliminate future disability payments in order to recover any overpayment balance that is not reimbursed.

For residents of all states EXCEPT Arizona, Alabama, California, Colorado, Florida, Kentucky, Maine, Maryland, New Jersey, New York, Ohio, Oklahoma, 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 Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

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 information to obtain or amend insurance coverage or to make a 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 and 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 Ohio: Any person who, with intent to defraud or knowing 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.

For residents of Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

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.

Signature - Please read the statement that applies to your state of residence and sign the bottom of the page.

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.

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.

The statements contained in this form are true and complete to the best of my knowledge and belief.

_____ _____

Signature Date

Electronic Funds Transfer (EFT) is our standard method of payment. When making our claim decision we may contact you to obtain your banking information.

PART - III

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I allow all doctors, hospitals, other health care providers, pharmacy, pharmacy benefit managers, government agencies (including, but not limited to, Federal, State or Local, and the Social Security Administration and Veterans Administration), insurers, employers, financial institutions, educational institutions, health plans, health insurance carriers, policyholders, contract holders, vendors, health and benefit insurers and administrators or their successors ("Records Holders") to give to and discuss with The Hartford and its representatives, the following personal, private, or privileged information, records, or documents related to:

Insured's Name (Please Print)	Date of Birth	Employer/Policyholder's Name:
_____	_____	_____

Any and all medical information or records, including medical histories, physical, mental, or diagnostic examinations, pharmaceutical records, and treatment notes, and including information regarding HIV/AIDS, communicable diseases, alcohol or substance abuse, and behavioral or mental health (but excluding psychotherapy notes); work and performance information and history, including job duties and earnings; information on any insurance coverage and claims filed, including all records and information related to such coverage and claims; financial information, including pension benefits and bank records; business transaction billing and payment records; academic transcripts; and any and all information concerning Social Security or other government 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 by The Hartford (including subsidiaries and affiliates) for the purpose of evaluating and administering my claim(s) for benefits and /or leave request(s) and/or request(s) for accommodation. Such information shall be referred to herein collectively as “My Information.”

I understand that once My Information has been disclosed to The Hartford as permitted under this Authorization, it may be re-disclosed by The Hartford as permitted by law or my further authorization. Without limiting the foregoing, I authorize The Hartford to use or disclose My Information (i) to my employer for: a) functions related to accommodating my restrictions/limitations, including in accordance with law; b) responding to claims related to accommodation, adverse or discriminatory treatment related to my claim or condition; c) responding to complaints by me or my representative relating to benefits, leave or accommodation; d) responding to any litigation, agency or regulatory proceeding, grievance, alternative dispute resolution, or lawful subpoena (including regarding employment claims); e) federal, state, or other leave administration; f) fulfilling fiduciary obligations under my benefit plan; or (g) claim, other audits or benefit program reviews; (ii) to administrators or other service providers, including health and wellness vendors, of my employer’s benefit plan(s) and/or programs, including leave management, for plan, benefit, or program related functions or data aggregation and analysis; (iii) to any electronic claim systems or programs or third party vendors used for claims administration or processing or to any insurance broker to carry out functions related to my benefit plan/program or claim; (iv) to any health care professional who has treated or evaluated me or who may do so; (v) to other persons or entities performing business, medical, or legal services related to my claim; (vi) for other insurance, reinsurance or analytical purposes, including workers’ compensation insurance, Social Security Disability insurance, or subrogation or reimbursement purposes ; (vii) as may be lawfully required; (viii) as may be reasonably necessary to protect the personal safety of others or myself; (ix) as may be reasonably necessary to respond to regulatory or similar complaints; and (x) as may be reasonably necessary to prevent or detect perpetration of a fraud. I understand that My Information disclosed to The Hartford and re-disclosed to others could include information regarding alcohol and substance abuse, HIV/AIDS, other communicable diseases, and behavioral and mental health records.

(Continue to next page)

I understand that once my Information is given out as allowed in this form, federal privacy laws may not protect it and it may be re-disclosed by The Hartford. I also understand that information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient. The Authorizations set forth herein expire two years from the date listed below, or upon my written revocation, if earlier, except as may be reasonably necessary to prevent or detect perpetration of a fraud, adjudicate a benefits claim, respond to regulatory or similar complaints, or protect the personal safety of others or myself. I understand that if The Hartford is the administrator of my employer's self-insured disability program or leave program that my employer is entitled to receive my records without this Authorization. I understand that a revocation of this Authorization is not effective to the extent that any of my Record Holders or The Hartford has relied on this Authorization or to the extent that the Hartford has a legal right to contest a claim for benefits or to contest the policy. If I do not sign this Authorization, The Hartford may not be able to review my claim and determine whether I am eligible for benefits. This may result in a delay or denial of my request for benefits.

The Information released under this Authorization can be submitted to The Hartford electronically, by phone or fax, or by mail. I agree that a copy of this Authorization may be treated as a signed original. I understand that I am entitled to receive a copy of this Authorization upon request. If there is a conflict between a prior request for restriction on the disclosure of My Information and this Authorization, this Authorization will control.

NOTICE TO INFORMATION PROVIDERS:
The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family members genetic tests, the fact that an individual or an individuals' family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. Please note that it is appropriate under GINA to provide family medical history when an employee is requesting leave to care for a family member.

_____ _____

Signature of Claimant or Legal Representative **Date**

_____

Name and Relationship to Claimant *(if signed by Legal Representative)*

Form must be signed and dated.

Mail forms to: P. O. Box 34220
Richmond, VA
23234

Phone number: 1-804-271-9426
Fax number: 1-804-271-9108
Email address: jennifer@chesterfiel

Clear Form

Attending Physician's Statement – Initial

THE HARTFORD

The patient is responsible for completion of this form without expense to the company

Patient Last Name:	Patient First (or Preferred) Name:	Date of Birth:	Claim Id Number:

Condition

Patient's condition is a result of:
☐ Illness ☐ Injury
☐ Pregnancy

If illness or injury, is condition related to:
☐ Work Activity
☐ Motor Vehicle Accident
☐ Intentional/Self-Inflicted

If pregnancy, what is date of delivery?
__/__/____ (MM DD YYYY)
☐ Actual ☐ Estimated

Condition onset:
__/__/____ (MM DD YYYY)

First day recommended out of work:
__/__/____ (MM DD YYYY)

Projected return to work date:
__/__/____ (MM DD YYYY)

Office visit to complete this form:
__/__/____ (MM DD YYYY)
☐ In Person ☐ Telemedicine

Disabling Diagnosis(es) and Impact to Function

ICD 10 Codes
Please provide most specific codes:
|__||__||__|.|__||__||__||__| \ |__||__||__|.|__||__||__||__|

Description of corresponding symptoms
_____
_____

Co-Morbid Conditions with Impact to Diagnosis

☐ None ☐ Opioid Usage ☐ Psoriasis ☐ Mental Health
☐ Diabetes ☐ Heart Disease ☐ Asthma/Bronchitis ☐ Cognitive Impairment
☐ Hypertension ☐ Obesity ☐ Auto-Immune Disease
☐ COPD ☐ Arthritis ☐ Other _____

In your opinion is the patient competent to endorse checks and direct the use of proceeds? ☐ Yes ☐ No

Treatment Plan

☐ Conservative treatment ☐ Bed Rest ☐ Palliative care ☐ Hospice Care

☐ Hospitalization Admittance date: __/__/____ (MM DD YYYY) Discharge date: __/__/____ (MM DD YYYY)

☐ Next/Another appointment Date: __/__/____ (MM DD YYYY) ☐ In Person ☐ Telemedicine

☐ Physical/Occupational therapy |__| times per week ☐ until __/__/____ (MM DD YYYY) ☐ Actual ☐ Estimated

☐ Surgery Date: __/__/____ (MM DD YYYY) CPT Code(s): |__||__||__||__||__| \ |__||__||__||__||__|

☐ Referral to a specialist Type: _____ Contact Info:_____

Current Medications (related to condition or impacting function)

☐ None ☐ Over counter medications: _____

☐ Prescription medications Name(s): _____

☐ Impacting function? ☐ Yes ☐ No If yes, why? _____

☐ Chemotherapy ☐ Radiation Start Date: __/__/____ (MM DD YYYY) End Date: __/__/____ (MM DD YYYY)

Mail forms to: P. O. Box 34220
Richmond, VA
23234

Phone number: 1-804-271-9426
Fax number: 1-804-271-9108
Email address: jennifer@chesterfield

THE HARTFORD

Attending Physician's Statement – Initial

The patient is responsible for completion of this form without expense to the company

Patient Last Name:	Patient First (or Preferred) Name:	Date of Birth:	Claim Id Number:

Level of Functionality (Based upon your medical findings and opinion, address the full range of your patient's abilities. We will conclude that there are no restrictions on function unless specified below.)

Expected duration of any restriction(s) or limitation(s) listed below THROUGH __/__/____
MM DD YYYY

In a workday the patient is able to: (select either Continuous or Intermittent)

	Continuously with standard breaks		Intermittently with standard breaks	If intermittent, enter time for each section below	
				Hours at one time	Total hours in a workday
Sit	☐	or	☐	|___|	|___|
Stand	☐	or	☐	|___|	|___|
Walk	☐	or	☐	|___|	|___|

Key: C = Continuously (5.5 – 8 hours) F = Frequently (2.5 – 5.5 hours) O = Occasionally (up to 2.5 hours) N = Never

Activity Ability	C	F	O	N	Activity Ability	Right/Left	C	F	O	N
☐ Drive	☐	☐	☐	☐	☐ Squat / Kneel		☐	☐	☐	☐
☐ Weight bearing	☐	☐	☐	☐	Hand Dominance	☐ R ☐ L				
☐ Climb	☐	☐	☐	☐	☐ Fine Manipulation	☐ R ☐ L	☐	☐	☐	☐
☐ Bend	☐	☐	☐	☐	☐ Gross Manipulation	☐ R ☐ L	☐	☐	☐	☐
☐ Max lift	____LBS	____LBS	____LBS	____LBS	☐ Reach above shoulder	☐ R ☐ L	☐	☐	☐	☐
☐ Max Carry	____LBS	____LBS	____LBS	____LBS	☐ Reach below shoulder	☐ R ☐ L	☐	☐	☐	☐

Completed or Planned Diagnostic Tests, Labs and Imaging (related to the disabling diagnosis)

Completed: ☐ X-ray __/__/____ ☐ MRI __/__/____ ☐ CT __/__/____ ☐ EKG __/__/____
MM DD YYYY

☐ ECHO __/__/____ ☐ EMG __/__/____ ☐ Lab Work __/__/____

Findings of completed tests: ☐ No significant findings ☐ Confirmed diagnosis

Planned: ☐ X-ray ☐ MRI ☐ CT ☐ EKG ☐ ECHO ☐ EMG ☐ Lab Work Scheduled date __/__/____
MM DD YYYY

Provider Details

Provider Name: _____
Specialty: _____
EIN Number: _____
License Number: _____

Email: _____
Phone: (___) ___-____
Fax: (___) ___-____

Provider Signature: _____

Date: __/__/____
MM DD YYYY