

# How to File a Medical Claim

(For Special Risk, Sports, Campers, Youth Groups, and Tripster Policies)



Attached is a Blanket Lines Notice of Claim (Claim Form) for your accident policy  
Please forward claims and questions to the following address:

Hartford Life Claims  
Blanket Lines Unit  
P.O. Box 3856  
Alpharetta, GA 30023  
Toll Free Number: (800) 678-6702  
Fax Number: (866) 954-3993

**Step 1 - Submit a completed Notice of Claim (claim form) to our office either by fax or mail.**

**The Policyholder (not the Parent, Claimant or Agent) should:**

- Fully answer each item in the Policyholder Certification section and sign the Policyholder Certification statement at the bottom of this section.
- Read and sign the Fraud Warning Certification statement located on the reverse side of the Notice of Claim.

**The Parent/Guardian or Adult Claimant should:**

- Fully answer each question in the Claimant Certification section (choose either the Parent/Guardian column or the Adult Claimant column; which ever is applicable) and sign the Parent/Guardian or Adult Claimant Certification statement at the bottom of this section.
- Read and sign the Fraud Warning Certification statement located on the reverse side of the Notice of Claim.

**Step 2 - Submit itemized medical bills for payment consideration to our office. If the policy is Excess (please consult with the Policyholder or our office if you are unsure of this), also include any other insurance carrier's corresponding Explanation of Benefits (EOBs) as outlined in the helpful information bullet listed below.**

*Helpful information for submitting claims and expediting payment*

- A complete Notice of Claim is required for each accident/injury a Claimant incurs.
- A complete Notice of Claim must be submitted even if an ACORD form is being provided.
- Providers may wish to bill us directly for their services. If they do, please ensure a Notice of Claim has first been submitted to our office.
- Itemized medical bills (including claimant name, date of service, diagnosis, procedure codes, amount charged, and provider information) should be submitted for processing. "Balance Due" statements and/or incomplete bills do not provide enough claim detail to process the charges. In order to ensure we receive complete claim information, we suggest providers submit standardized billing statements (called "UB-04" for hospital charges and/or a "CMS-1500" for physician charges).
- If this Policy is Excess and the Claimant has other insurance coverage, medical bills should first be submitted to your other insurance carrier for payment. Once they have processed the charges (either paid or denied), then submit a copy of your provider's itemized medical bill and the other carrier's coordinating Explanation of Benefits (EOB) to our office for processing. Important - we are unable to make a claim determination without both of these items; claim payment will be expedited if the medical bill and EOB are submitted at the same time.
- Unless proof of payment is submitted with the medical bill (a copy of check, a medical bill that indicates the claimant has made all or partial payment or zero balance information) claim payment is generally sent directly to the medical providers.

Please detach this page and forward the completed Notice of Claim (and medical bills if you are submitting expenses for payment) to the address listed above. We recommend you keep copies of the correspondence you are submitting to use for future reference.

**HARTFORD FIRE INSURANCE COMPANY  
HARTFORD LIFE INSURANCE COMPANY  
HARTFORD LIFE & ACCIDENT INSURANCE COMPANY**



**Notice of Claim**

FOR SPECIAL RISK, SPORTS, CAMPERS, YOUTH GROUPS & TRIPSTER POLICIES

Hartford Life Claims, P.O. Box 3856, Alpharetta, GA 30023 Toll Free (800) 678-6702 Fax (866) 954-3993

**POLICYHOLDER CERTIFICATION - To be completed by Policyholder Official**

Policyholder Number		Policyholder Name	
Policyholder Address (Street, City, State & Zip Code)			Policyholder Phone Number ( )
Agent Name			Agent Phone Number ( )
Claimant (Injured Party) Name		Claimant Date of Birth	Claimant Phone Number ( )
Claimant Address (Street, City, State & Zip Code)			
Date of Accident	Time of Accident (hh:mm) <input type="checkbox"/> AM <input type="checkbox"/> PM	Place of Accident	
Cause of Accident		Indicate injured body part(s)	
Nature of Sickness (if applicable)			Date Sickness first commenced
<i>Policyholder Certification Signature Required</i>			
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. I further certify I have <b>read and signed</b> the Fraud Warning statement located on the reverse side of this form.			
Title of Policyholder Official		Signature of Policyholder Official	Date

**CLAIMANT CERTIFICATION - To be completed by Parent/Guardian or Adult Claimant**

<p><b><u>Parent/Guardian completes for dependent child</u></b></p> <p>Does the Claimant have medical coverage through?</p> <p>Mother's employers policy*    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>Father's employers policy*    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>Guardian's employers policy* <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>Medicare policy                    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>Medicaid policy                   <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>Any other medical policy*      <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>If yes, provide details: _____</p> <p>*If yes and this Policy is Excess, please include the other insurance carrier's Explanation of Benefits (EOBs) for each medical bill submitted.</p>	<p><b><u>Adult Claimant completes</u></b></p> <p>Do you have medical coverage through?</p> <p>Your employer*                    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>Spouse's employer*                <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>Medicare policy                    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>Medicaid policy                   <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>Any other medical policy*        <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>If yes, provide details: _____</p> <p>*If yes and this Policy is Excess, please include the other insurance carrier's Explanation of Benefits (EOBs) for each medical bill submitted.</p>
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*Parent/Guardian or Adult Claimant Certification Signature Required:*

I certify the above information to be true and accurate to the best of my knowledge. I further certify I have **read and signed** the Fraud Warning Certification statement located on the reverse side of this form. I also authorize any physician/hospital that has attended me or my dependent child to disclose any information thus acquired for the purposes of this claim payment.

Printed Name Parent/Guardian or Adult Claimant \_\_\_\_\_

Signature of Parent/Guardian or Adult Claimant \_\_\_\_\_

Date \_\_\_\_\_

**FRAUD WARNING CERTIFICATION** - 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 Official

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian or Adult Claimant

\_\_\_\_\_  
Date