Participant Accident
Statement of Claim for
Medical Expense 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 Medical Expense benefits under a Participant Accident policy.

Step 1: Submit a completed Notice of Claim to our office by fax or mail

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 – Claimant's Statement

☐ Form is to be completed in its entirety and signed by the Claimant or their parent/guardian.

☐ Read and sign the Important Notice on page 4.

Step 2: Submit itemized medical bill(s) and supporting documentation (see below)

Helpful Information for submitting claims and expediting payment

- If the Participant Accident Policy provides coverage on an Excess basis, you must file your bills through your primary insurance carrier prior to filing for benefits under this Policy. The Explanation of Benefits (EOB) that corresponds with the medical bill(s) that have been processed by the other carrier must be submitted with your claim. Please consult the Policyholder or our office if you are unsure of the Policy's scope of coverage.
- A fully-completed Notice of Claim is required for each accident/injury a Claimant incurs. Submitting incomplete information will delay the processing of your claim.
- 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(s) of service, diagnosis, procedure code(s), amount charged, and provider information) should be submitted for processing. "Balance Due" statements and/or incomplete bills do not provide enough detail to process the charges. Accordingly, we recommend providers submit standardized billing statements, specifically, UB-04 forms for hospital charges and/or CMS-1500 forms for physician charges.
- Claim payment is sent directly to the medical providers unless proof that a Claimant has paid the bill in whole or in part (e.g., a copy of check or balance statement) is received.

Please detach this page and forward the completed Statement of Claim and supporting documentation to the address listed below. We recommend you retain copies of the items you have submitted for future reference.

Submit claim by mail to: P.O. Box 189
Bridgton, ME 04009

Phone number: 1-888-998-2240
Fax number: 1-207-647-4569
Email address: claims@nahga.com

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.

The Hartford Financial Services Group, Inc., (NYSE: HIG) operates through its subsidiaries, including underwriting companies Hartford Life and Accident Insurance Company and Hartford Fire Insurance Company, under the brand name, The Hartford®, and is headquartered at One Hartford Plaza, Hartford, CT 06155. For additional details, please read The Hartford's legal notice at www.thehartford.com. The Hartford is the administrator for certain group benefits business written by Aetna Life Insurance Company and Talcott Resolution Life Insurance Company (formerly known as Hartford Life Insurance Company). The Hartford also provides administrative and claim services for employer leave of absence programs and self-funded disability benefit plans.

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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: 10-BSR-104934	Policyholder Name: Bourne Public Schools, MA	
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

Medical Expense benefits claimed due to:

☐ Contagious and Infectious Disease ☐ Accidental Injury ☐ Heart or Circulatory Malfunction ☐ Sickness

For claims due to injury, complete the following:

Date of Accident:	Time of Accident (hh:mm): ☐AM ☐PM	Place of Accident:
Nature of injury(ies):		

Fully describe the circumstances of the Accident (Use a separate sheet of paper, if necessary):

For claims due to illness, complete the following:

Nature of illness:	Date illness first commenced:

Fully describe the circumstances of the sickness (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 injury/illness, if available.
- Incident/police reports relating to the Incident.

I hereby 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 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 – CLAIMANT'S STATEMENT – To be completed by the Adult Claimant or parent/guardian if Claimant is a minor

A. Information about the Claimant

Name: (Last, First, Middle Initial)	Date of Birth:	Social Security Number:
Address: (Street, City, State, & Zip Code)		Gender: ☐ Male ☐ Female

Name of Parent/Guardian and relationship to Claimant (if applicable):

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

Please indicate any other sources of medical insurance under which the Claimant is covered:

Medicare	☐	Mother's Employer's policy*	☐
Medicaid	☐	Father's Employer's policy*	☐
Employer's policy*	☐	Guardian's Employer's policy*	☐
Spouse's Employer's policy*	☐	Any other medical policy*	☐

*If Yes and the Participant Accident Policy provides coverage on an Excess basis, please include the other carrier(s) Explanation of Benefits (EOB) for each medical bill submitted. Please consult the Policyholder or our office if you are unsure of the Policy's scope of coverage.

B. Information about the Claimant's condition

1. For 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):

2. For illness, answer the following questions:

What were the first symptoms?	
When did the symptoms begin?	Has the claimant had this illness before? ☐ Yes ☐ No If Yes, when?

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

Date of initial treatment:	Nature of treatment received to date:

Is further treatment anticipated? ☐ Yes ☐ No If Yes, nature and duration of expected treatment:

C. Certification

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 Important Notice on page 4 of this form. I also authorize any physician/hospital that has attended me or my dependent child to disclose information acquired for claim payment purposes.

_____ _____
Signature of Adult Claimant or Parent/Guardian Date

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

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.

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 _____