



# HARTFORD LIFE INSURANCE COMPANY

Hartford Life

## 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:

<u>Name of Doctor</u>	<u>Address</u>	<u>Telephone #</u>	<u>Date</u>

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