GROUP ACCIDENT, CRITICAL ILLNESS/SPECIFIED DISEASE & HOSPITAL INDEMNITY CLAIM FORM

Attending Physician/Medical Professional Statement (APS)

for Accident, Critical Illness/Specified Disease & Hospital Indemnity

Hartford Life and Accident Insurance Company

In furnishing this form, The Hartford ® does not waive any of its rights or defenses nor admit liability. The Hartford

PREGNANCY

GROUP ACCIDENT, CRITICAL ILLNESS/SPECIFIED DISEASE & HOSPITAL INDEMNITY CLAIM FORM

Attending Physician/Medical Professional Statement (APS)
Critical Illness/Specified Disease Supplement

Hartford Life and Accident Insurance Company

In furnishing this form, The Hartford® does not waive any of its rights or defenses nor admit liability. The Hartford® is The Hartford Financial Services Group, Inc., and its subsidiaries.

Physician/Medical Professional Responsibilities:

1) Complete the sections of the form applicable to the illness/condition, then sign and date this form. For assistance, please call (866)547-4205.
2) Provide all relevant supporting documentation such as medical statements/records, radiology/pathology reports, test/imaging results, etc. The claimant is responsible for any fees charged for proof requirements.
3) Submit the form and required documentation to The Hartford Supplemental , Q V X U Benefit Department, PO Box 99906, Grapevine, TX 76099; or I Dtp (469)417 Birth

PATIENT INFORMATION

Patient Name (First MI Last) Date of Birth

ILLNESS/CONDITION INFORMATION – CONTINUED*

Illness/Condition	Medical Documentation (as applicable)	Additional Information
F Advanced Alzheimer's Disease	CT, MRI, PET, CSF, neurological exam	ƒ FAST Stage: _____ ƒ MMSE Score: _____ ƒ Date of initial (first ever) diagnosis: _____
F Advanced Multiple Sclerosis	MRI, CSF, EP, neurological exam	ƒ Has the condition produced at least 2 neurological abnormalities? F Yes F No

GROUP