



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>

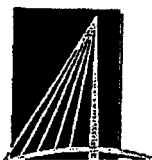
Notice to all claimants: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, is guilty of insurance fraud.

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 _____ 20_____ Signed (patient, or parent if minor) _____

If someone other than patient executed this form and authorization, indicate reason: _____

Relationship to Patient: _____ Address: _____



For Questions or Claim Information
**BAY BRIDGE
ADMINISTRATORS**
P.O. Box 161690
AUSTIN, TEXAS 78716

Only complete this side of the form if you are Assigning Benefits.

WARNING

If you sign this assignment, all benefits payable will be paid to the designated Provider. Complete *only* if assigning benefits.

Authorization to Pay: I hereby authorize payment directly to the undersigned physician of the surgical and/or medical benefits, if any, otherwise payable to me for his services as described below but not to exceed the reasonable and customary charge for these services. I understand that I am financially responsible for the charges not covered by this authorization.

Date _____ 19_____ Signed (Insured Person) _____

Attach Provider's computer generated itemized bill.

Date	Signature (Attending Physician)	Degree	Tax I.D. No.
Street Address	City or Town	State or Province	Zip Code