ACCELERATED BENEFIT (LIVING BENEFIT OPTION)
Claim Forms for Employee/Member or Dependent

THE HARTFORD

EMPLOYER'S/POLICYHOLDER'S RESPONSIBILITY

1. Complete, sign and date the **Employer/Policyholder Statement** on page 2 of this form.

2. Provide proof of Insured Person's salary as defined in the Policy (attach most recent W2 or commissions, if applicable). If any portion of the Group Life coverage was elected, please attach a copy of the enrollment history for the Amount of Life Insurance in force. If claim is for a Dependent, include Dependent's name and social security number and documentation of enrollment.

3. If you indicated on page 2 that the Employee/Member has designated an Irrevocable Beneficiary, attach a copy of this document. Indicate to the Employee/Member that the **Consent Form** on page 7 should be completed by an Assignee or Irrevocable Beneficiary and returned to The Hartford.

4. Give the remaining sections of this form, including this instruction sheet to the Employee/Member. He/She should: (1) complete the **Employee/Member Section** on page 3 and then return the completed form to The Hartford; and (2) give the **Attending Physician's Statement** on page 5 to his/her physician for completion.

EMPLOYEE'S/MEMBER'S RESPONSIBILITY

1. Complete, sign and date the **Insured Employee or Member Statement** on page 3. Please read and sign the Important Notice on page 4, and read the Disclosure Form on page 6.

2. Give the **Attending Physician's Statement** on page 5 to your physician and ask that he/she complete the form and return it to The Hartford.

3. If you have assigned any portion of your Life Insurance or have designated an Irrevocable Beneficiary, please have your Assignee or Irrevocable Beneficiary complete, sign and date the **Consent Form for Payment** on page 7. Upon completion, return this form to The Hartford with your completed Statement.

Please note that this option may be exercised only once for You and only once for each of Your Dependents

Mail completed form(s) to: The Hartford
Group Life Claims
P. O. Box 14299
Lexington, KY 40512-4299

By Fax to: 1-866-954-2621

By E-Mail to: gbclaimcslife@thehartford.com

For questions about how to complete this form, call Hartford Life Toll-free at 1-888-563-1124

IN FURNISHING THIS FORM **THE HARTFORD®** DOES NOT WAIVE ANY OF ITS RIGHTS OR DEFENSES NOR ADMIT LIABILITY

GROUP LIFE CLAIM DIVISION

Clear Form

STATEMENT OF CLAIM FOR ACCELERATED BENEFIT (LIVING BENEFIT OPTION)

THE HARTFORD

EMPLOYER/POLICYHOLDER STATEMENT

(Please verify if the employee qualifies for any other group benefits through The Hartford and submit the claim accordingly)

Full Name of Employee (Last, first, middle initial)			Employee Social Security Number
Employer State of Nebraska	Branch or Subsidiary	Classification	Occupation
Policy Number 803617	Effective Date of Employee's Insurance	Date of hire	Date Last Actively at Work

Claim is for: (check one) ☐ Claim is for Employee/Member ☐ Claim is for Dependent of Employee/Member

If Employee/Member claim, give reason employee/member did not return to work after last day worked:

If Dependent claim, provide Name of Dependent: _____

Social Security Number of Dependent:

Have premiums been paid to date for this insured? ☐ Yes ☐ No

AMOUNT OF INSURANCE Basic Life: $ _____ Supplemental Life: $ _____

Benefit based on previous year's W-2? ☐ Yes ☐ No

(Complete only if amount of insurance is based on earnings schedule.)

Rate of basic earnings on date last worked: $ _____ ☐ Hourly ☐ Weekly ☐ Monthly ☐ Annually

Was a claim for Long Term Disability or Waiver of Premium submitted to The Hartford prior to date of death? ☐ Yes ☐ No

Was an application for conversion completed? ☐ Yes ☐ No

Has claimant: 1. assigned any portion of this Life Insurance to another party? ☐ Yes ☐ No

2. designated an irrevocable beneficiary? ☐ Yes ☐ No (If "Yes", attach a copy of designation.)

If "Yes" was checked for #1 or #2 above, the Employee or Member should give the Assignee or Irrevocable Beneficiary page 7 of this form, Consent Form for Payment of Accelerated Benefit (Living Benefit Option), for completion. Once completed, it should be attached to this form when the claim is submitted.

EMPLOYER CERTIFICATION

I hereby certify that the information provided is true and complete according to the records of the Employer.
I agree that this information is subject to audit by The Hartford® and/or its representative.

Name of Employer:	Telephone Number of Authorized Representative:
State of Nebraska	(402) 471-3247

Address of Employer: *(Street, City, State & Zip Code)*
1526 K Street, Suite 110, Lincoln, NE 68508

Certified by their Authorized Representative: *(Please print)*
Shannon Soriente

Signature of Authorized Representative:	Date:

NOTE: PLEASE BE SURE INSURED/EMPLOYEE RECEIVES ALL 7 PAGES OF THIS FORM.

Mail completed form(s) to: The Hartford
Group Life Claims
P. O. Box 14299
Lexington, KY 40512-4299
Fax to: 1-866-954-2621
E-Mail to: gbclaimcslife@thehartford.com

STATEMENT OF CLAIM
FOR ACCELERATED BENEFIT (LIVING BENEFIT OPTION)

THE HARTFORD

INSURED EMPLOYEE OR MEMBER STATEMENT

Full Name of Insured *(Employee/Member)* | Date of Birth

Address of Insured *(Employee/Member) (Number, Street, City, State & Zip Code)*

Nature of Illness or Injury Causing Present Disability

On what date were you first totally disabled so that you were wholly unable to work? _____

Are you now wholly unable to work?
☐ Yes ☐ No

Have you applied for a Conversion Life policy from Hartford Life?
☐ Yes ☐ No

Amount of Accelerated Benefit (Living Benefit Option) requested*: $_____

*Note: **This option may be exercised only once for You and only once for each of Your Dependents.** The amount being requested may not exceed the percentage of the Employee/Insured's Life Insurance Amount set forth in the policy and is subject to the minimum and maximum amounts contained in the Policy. Accelerated benefits may be taxable and may affect eligibility for public assistance. **We recommend that you consult with your Tax Advisor with any questions.**

Names and addresses of Physicians who have treated you during Present Disability

Name of Physician | Treatment Dates From: To:

Address *(Number, Street, City or Town, State & Zip Code)*

Name of Physician | Treatment Dates From: To:

Address *(Number, Street, City or Town, State/Zip Code)*

I hereby certify that the information provided by me in this Statement of Claim form is true and complete to the best of my knowledge and belief, and that I have read and understand the statements on page 4 of this form. I hereby authorize any hospital or physician who has attended or examined me to disclose to The Hartford® or any of its representatives all information acquired by reason of, and records pertaining to, such hospitalization, examination and attendance. My consent is hereby granted to use this original form or a photocopy as equally valid authorization.

☐ I acknowledge that I have received and read the Disclosure Form on page 6 of this form. If any portion of the Life Insurance was assigned, or if there is an irrevocable beneficiary, page 7 is completed and attached.

_____ _____
Signature of Insured *(Employee/Member)* Date

_____
Witness:

Mail completed form(s) to: The Hartford
Group Life Claims
P. O. Box 14299
Lexington, KY 40512-4299
Fax to: 1-866-954-2621
E-Mail to: gbclaimcslife@thehartford.com

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, California, Colorado, Florida, Kentucky, Maine, Maryland, New Jersey, New York, Oregon Pennsylvania, Puerto Rico, Tennessee 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 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 California: For your protection, California law requires the following to appear on this form: 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 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 or 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 nformation 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 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.

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 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.

Signature _____ Date _____

STATEMENT OF CLAIM
FOR ACCELERATED BENEFIT (LIVING BENEFIT OPTION)

THE HARTFORD

STATEMENT OF ATTENDING PHYSICIAN

Your patient has requested an advanced payment of benefits on his/her group life insurance policy carried through The Hartford®. To qualify for this benefit, the patient must have a medical condition that, with reasonable medical certainty, will result in the death of the insured in less than (6) (12) (24) months from the date of this statement. Your assistance is requested to help us determine your patient's eligibility.

Name of Patient	Date of Birth	Social Security Number

What is the disease causing this patient to be terminally ill? Please provide the diagnosis and subjective findings.

When did symptoms first appear?	Date patient was informed of diagnosis	First treatment date	Last treatment date

Frequency of treatment: ☐ Daily ☐ Weekly ☐ Monthly ☐ Other _____

Has this illness affected the mental capacity of the patient? ☐ Yes ☐ No

If "Yes," is the patient still capable of managing his own affairs? ☐ Yes ☐ No

Has the patient ever had the same or similar condition? ☐ Yes ☐ No If "Yes," please state when _____ and describe:

Will the patient's condition, with reasonable certainty, result in the patient's death within:

☐ 6 months ☐ 12 months ☐ 24 months

Name of Physician	Degree	Specialty

Address of Physician *(Number, Street, City, State & Zip code)*	Telephone Number (402)

Signature of Physician	Date

Mail completed form(s) to: The Hartford
Group Life Claims
P. O. Box 14299
Lexington, KY 40512-4299
Fax to: 1-866-954-2621
E-Mail to: gbclaimcslife@thehartford.com

Should The Hartford require additional information, we will contact you.

IMPORTANT – READ CAREFULLY

DISCLOSURE FORM
ACCELERATED BENEFIT (LIVING BENEFIT OPTION)

You have elected the Accelerated Benefit (Living Benefit Option) available under your group life insurance coverage offered through your employer and underwritten by The Hartford®. As a result of electing this option, the total face amount of your group life insurance coverage will be reduced by the amount of the Accelerated Benefit (Living Benefit Option). The effect of electing this option is to accelerate payment of a portion of your group life insurance proceeds. The premium for the reduced amount of group life coverage will, under normal circumstances, be lower.

EXAMPLE SITUATION:

An Insured Person has a $50,000 Amount of Life Insurance under a group life insurance policy. The Insured Person requests 50% of this Amount of Life Insurance under the Accelerated Benefit (Living Benefit Option). This requested amount would equal $25,000. ($50,000 x 50% = $25,000). As a result of the accelerated payout, the Insured Person's Amount of Life Insurance will be reduced to $25,000 ($50,000 - $25,000 = $25,000).

AS A RESULT OF ELECTING THE ACCELERATED BENEFIT (LIVING BENEFIT OPTION), YOU SHOULD BE AWARE OF THE FOLLOWING:

1) Receipt of an accelerated benefit option may adversely affect your right to receive certain public funds such as Medicare, Medicaid, Social Security, Supplemental Security Income and possibly others.

2) Receipt of an accelerated benefit payment may be taxable. See your personal tax advisor for further information.

3) Any accelerated benefit payments received are intended to qualify under Section 101 (g) (26 U.S.C. 101(g)) of the Internal Revenue Code of 1986 as amended by Public Act 104-191.

4) The Accelerated Benefit (Living Benefit Option) does not apply to any Accidental Death and Dismemberment coverage, and no payment of an Accelerated Benefit (Living Benefit Option) will reduce or otherwise affect the amount of benefits available to you under any applicable Accidental Death and Dismemberment.

RELEASE FROM ASSIGNMENT

If you have executed an assignment of interest with respect to your Amount of Life Insurance, The Hartford® must receive a release from the individual to whom the assignment was made before any benefits are payable under the Accelerated Benefit (Living Benefit Option). The form required for this release, Consent Form for Payment of Accelerated Benefit (Living Benefit Option), is on page 7 of this form.

CONSENT FORM FOR PAYMENT OF ACCELERATED DEATH BENEFIT (LIVING BENEFIT OPTION)

THE HARTFORD

Policy Number:	Policyholder Name:

Insured's Name:

I _____, the (check one below):

☐ Assignee ☐ Irrevocable Beneficiary

of the above named policy, acknowledge that _____ has requested
Name of Insured

payment of an Accelerated Death Benefit (Living Benefit Option) under his/her Certificate.

I hereby consent to the payment of an Accelerated Death Benefit (Living Benefit Option) to _____
Name of Insured.

I understand that the payment of an Accelerated Benefit (Living Benefit Option) reduces the amount of insurance payable on the death of _____ by the amount of the Accelerated Death Benefit. (Living Benefit Option) paid.
Name of Insured

By executing this consent, I hereby release The Hartford® from any and all liability to the extent of the Accelerated Death Benefit (Living Benefit Option) paid.

_____
Signature

_____
Date

Subscribed and sworn before me:

This _____ day of. _____, 20 _____

_____
Notary Public