

Accident Report

TO BE FILED BY THE INSURED OR THE PARENT
OR GUARDIAN OF THE INSURED



HARTFORD FIRE INSURANCE COMPANY
HARTFORD LIFE INSURANCE COMPANY
HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

APPLICATION FOR BENEFITS FOR POLICY # _____

Name of Insured _____ Social Security # _____ Date of Birth _____

Street _____ City _____ State _____ Zip _____

Is the Insured Yes If "Yes," Name of Parent or Guardian _____
a Dependent No Telephone No. _____

Employer of Insured _____

Street _____ City _____ State _____ Zip _____

Employer of Parent or Guardian (if a dependent) _____

Street _____ City _____ State _____ Zip _____

Date of Accident	Where and how did Accident occur? _____
MO DAY YEAR	
<input type="text"/>	<input type="text"/>
Approximate time	
_____ AM	
_____ P.M.	

Name of Attending Physician _____

Address of Attending Physician _____ City _____ State _____ Zip _____

Dates treated _____ Hospitalized? Yes No If "Yes," Hospital Name _____
Dates hospitalized From _____ To _____

Is this a recurrent condition? Yes No If "Yes," when, and by whom previously treated? _____

State the name of any other insurance company or union plan under which the insured is covered for Hospital or Medical Expenses _____
Policy # _____ Deductible Amount _____

is the insured covered by Blue Cross/Blue Shield? Yes No If "Yes," Certificate Number _____

Have you filed for benefits or notified the physician of any other insurance? Yes No If "Yes," Amount of allowance _____

IMPORTANT: These benefits take up where other insurance benefits, if any. Be sure to file for benefits under any other hospital, surgical or medical insurance plan so that your covered expenses may be considered without delay. If your other insurance is Blue Cross/Blue Shield, give your certificate number to the physician and/or hospital.

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 or a photocopy as equally valid authorization.

Date _____ Signature _____

Please read the statement that applies to your residence and sign the bottom of the page.

For residents of all states EXCEPT California, Florida, New Jersey, Colorado, Pennsylvania, Arkansas, New Mexico, Louisiana, New York, Oregon, Virginia and Puerto Rico: A person commits a fraudulent insurance act if that person knowingly, and with intent to defraud any insurance company or other person, either: (a) files an application for insurance or statement of claim containing any materially false information, or (b) conceals information concerning any material fact in order to obtain an insurance policy or a benefit under an insurance policy. **A fraudulent insurance act is a crime.** The Hartford shall pursue prosecution of any fraudulent insurance act to the fullest extent of the law

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 New Jersey, Arkansas, and New Mexico: 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 an insurance policy is subject to criminal and civil penalties

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 thereto commits a fraudulent insurance act, which is a crime and subjects a person to criminal and civil penalties

For residents of Colorado: It is unlawful to knowingly provide false, incomplete, or misleading 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 its agent who knowingly provides false, incomplete, or misleading information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to an insurance settlement or award shall be reported to the Colorado Division of Insurance.

FOR RESIDENTS OF CALIFORNIA: FOR YOUR PROTECTION, CALIFORNIA LAW REQUIRES THE FOLLOWING TO APPEAR ON THIS FORM: "ANY PERSON WHO KNOWINGLY PRESENTS A 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 Louisiana: 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 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 Puerto Rico: Any person who knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years

ATTENDING PHYSICIAN'S STATEMENT - ACCIDENT REPORT

Patient's Name and Address

Diagnosis and Concurrent Conditions (If fracture or dislocation, describe nature and location)															
When did symptoms first appear or accident happen? When did patient first consult you for this condition? Has patient ever had same or similar condition? [If "Yes," state when and describe]	Date _____ Date _____ <input type="checkbox"/> Yes <input type="checkbox"/> No														
Nature of Surgical Procedure, if any (Describe fully) Charge to patient for this procedure, including post-operative care If performed in hospital, give name of hospital	Date performed _____ \$ _____ <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient														
Give dates of other medical (non-surgical) treatment, if any	<table style="width:100%; border-collapse: collapse;"> <tr> <td></td> <td style="text-align: right;">Charge per</td> </tr> <tr> <td>Call</td> <td style="text-align: right;">\$ _____</td> </tr> <tr> <td>Office</td> <td style="text-align: right;">\$ _____</td> </tr> <tr> <td>Home</td> <td style="text-align: right;">\$ _____</td> </tr> <tr> <td>Hospital</td> <td style="text-align: right;">\$ _____</td> </tr> <tr> <td>Nursing Home</td> <td style="text-align: right;">\$ _____</td> </tr> <tr> <td>Total (non-surgical) charges</td> <td style="text-align: right;">\$ _____</td> </tr> </table>		Charge per	Call	\$ _____	Office	\$ _____	Home	\$ _____	Hospital	\$ _____	Nursing Home	\$ _____	Total (non-surgical) charges	\$ _____
	Charge per														
Call	\$ _____														
Office	\$ _____														
Home	\$ _____														
Hospital	\$ _____														
Nursing Home	\$ _____														
Total (non-surgical) charges	\$ _____														
What other services, if any, did you provide patient? (Itemize, giving dates and fees)															
Were registered private duty nurses (R N) services necessary? Is patient still under your care for this condition? (If "No," give date your services terminated) To your knowledge, does patient have other Health Insurance or Health Plan coverage? (If "Yes," identify) Is condition due to injury or sickness arising out of patient/ employment? (If "Yes," explain)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No Date _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No														

(ANSWER ALL QUESTIONS ABOVE, IN ADDITION TO THOSE BELOW, IF DENTISTRY)

State exactly which teeth were involved in the accident and indicate them on the chart

8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
			E	D	C	B	A	A	B	C	D	E					
			RIGHT					LINGUAL					LEFT				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8		

Describe exact nature of injury

Describe condition of injured teeth prior to accident (check box) whole sound and natural filled capped artificial

REMARKS

Taxpayer Identification Applicable to above charges:	Social Security No.	Employer Identification No.
Date	Signature (Attending Physician)	Telephone No.
Street Address	City or Town	State or Province
		Zip Code