Group Life and Accidental Death Claim Forms for Employee or Dependent

THE HARTFORD

To the Employer

The loss of a valued employee, or their loved one, can be difficult and we want to assist you in filing the claim as quickly as possible. Please read all instructions below regarding completion of these forms.

- All claims must be submitted, along with the beneficiary designation form(s) on file with the Employer/Plan, if any. If none on file, the Policyholder/Employer shall certify to that fact on the claim form.

Submit claim by mail 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

PART I - EMPLOYER'S STATEMENT - TO BE COMPLETED IN FULL FOR ALL CLAIMS (1 of 2)
(Please verify if the employee qualifies for any other group benefits through The Hartford and submit the claim accordingly)

Policy Number(s): Life/AD&D: _____ AD&D: _____ Business Travel Accident: _____

Group Policyholder/Employer Name: _____

Name of Insured/Employee:	Social Security Number:	
Employee's Full Address:	Date of Birth:	Date of Death:

If you already have a copy of the death certificate, please submit it with the claim application.

Insured/Employee's Marital Status (if known): ☐ Married ☐ Divorced ☐ Single ☐ Widowed ☐ Partnered ☐ Unknown

Date of Hire:	Effective date of employee's Insurance:	☐ Salaried ☐ Hourly	Branch/Location:	Occupation:

Classification: Class (if known): _____ ☐ Full-time ☐ Part-time ☐ Union

Employee's actual date last physically at work: _____

Provide reason employee did not return to work on their next scheduled workday: _____

☐ Illness ☐ FMLA (provide approval form) ☐ Retirement - Date: _____ ☐ Other (please explain): _____

Premiums paid to date for Insured/Employee?: ☐ Yes ☐ No If No, date insurance was discontinued or not in force: _____

Indicate if any of the following apply to this Employee:

☐ Has been approved for LBO/Accelerated Death Benefits ☐ Has been Approved for Waiver of Premium

☐ Has been Approved for Long Term Disability ☐ Applied for Conversion ☐ Applied for Portability

AMOUNT OF INSURANCE BEING CLAIMED FOR EMPLOYEE OR AMOUNT IN FORCE FOR EMPLOYEE IF DEPENDENT CLAIM

- **Form is to be completed in its entirety and signed by the Official Representative of the Policyholder/Employer on page 2.**
- **Submission of claims on any voluntary or contributory Life plans, including Dependent coverage, must include copies of paper enrollment forms and/or online enrollment screen prints of current and two prior plan years for history of benefit elections and timely enrollment.**
- **AD&D Amount(s) should only be included if death was due to an accident.**

Basic Life: $	Supplemental Life: $
AD&D Basic: $	AD&D Supplemental: $

Earnings, if used to calculate Benefit Amount **(reported earnings should be as defined in your policy. Attach W-2 if applicable)**

Employee's Rate of Earnings used to calculate benefit Amount: $_____ ☐ Hourly ☐ Weekly ☐ Monthly ☐ Annually ☐ W-2

Regular number of hours scheduled to work (if applicable): _____	Effective date of above reported earnings: _____	Do earnings include commissions or bonuses?: ☐ Yes ☐ No

If Supplemental Life coverage is in force, was this elected during Annual Enrollment?: ☐ Yes ☐ No Date elected: _____	Did employee complete Evidence of Insurability (EOI)? ☐ Yes ☐ No Date EOI approved: _____

Does the coverage claimed above reflect age reductions?: ☐ Yes ☐ No

Please continue on next page

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PART I - EMPLOYER'S STATEMENT (2 OF 2)
BENEFICIARY / CONTACT INFORMATION - TO BE COMPLETED BY EMPLOYER/TPA FOR ALL CLAIMS

Do you have beneficiary designations on file? ☐ Yes ☐ No If Yes, please include all designations with your claim submission

- **Please provide beneficiary contact information below, if available. Otherwise, provide known contact information for next of kin or insured's emergency contact**

Has the beneficiary completed a Funeral Home Assignment, and provided it to you? ☐ Yes ☐ No

- **If Yes, please include the Funeral Assignment with your claimsubmission**
- **If No, please provide any Funeral Home information available to you:** _____

Name of Insured/Employee:		Social Security No.:
Beneficiary Name:	Date of Birth:	Relationship:
Full Mailing address:		
Telephone Number: ( )	Cell Number: ( )	E-mail Address:
Beneficiary Name:	Date of Birth:	Relationship:
Full Mailing address:		
Telephone Number: ( )	Cell Number: ( )	E-mail Address:
Beneficiary Name:	Date of Birth:	Relationship:
Full Mailing address:		
Telephone Number: ( )	Cell Number: ( )	E-mail Address:

DEPENDENT INFORMATION - ONLY COMPLETE FOR DEPENDENT CLAIM

- If dependent claim is for a child, provide necessary paperwork to support the dependent was a full-time student OR support the dependent child was incapacitated, as applicable. Our claim team can help you if you're unsure what paperwork is necessary.

Full name of Deceased Dependent	Deceased Social Security Number	Date of Birth	Date of Death	Relationship to Employee
Last Residence (number, street, City, State, Zip Code)	Is Employee Actively at Work? ☐ Yes ☐ No If No, complete date last worked and reason on page 1		Have premiums been paid to date for this dependent? ☐ Yes ☐ No	
Was the dependent child over the Policy's limiting age? ☐ Yes ☐ No	Was the dependent child a full-time student? ☐ Yes ☐ No If Yes, and required by the Policy, include school enrollment verification		Was dependent child incapacitated? ☐ Yes ☐ No	

AMOUNT OF INSURANCE BEING CLAIMED FOR DEPENDENT

- **Submission of claims on any voluntary or contributory Life plans, including Dependent coverage, must include copies of paper enrollment forms and/or online enrollment screen prints of current and two prior plan years for history of benefit elections and timely enrollment**
- **Include AD&D amount(s) only if death was due to an accident**

Basic Life: **$**	Supplemental Life: $	AD&D Basic: $	AD&D Supplemental: $
If Supplemental Dependent Life coverage is in force, was this elected during Annual Enrollment?: ☐ Yes ☐ No Date elected:		Did employee complete Evidence of Insurability (EOI) for Dependent?: ☐ Yes ☐ No Date EOI Completed:	
Dependent benefit is a: ☐ Flat Amount ☐ Percentage of Employee's amount If a percentage, please complete amount of employee insurance above		Does Coverage claimed reflect age reduction(s)? ☐ Yes ☐ No	

Indicate if any of the following apply to this Employee:

☐ Has been approved for LBO/Accelerated Death Benefits ☐ Has been Approved for Waiver of Premium
☐ Has been Approved for Long Term Disability ☐ Applied for Conversion ☐ Applied for Portability

TRAVEL INFORMATION – ONLY COMPLETE FOR BUSINESS TRAVEL ACCIDENT CLAIMS

- **If available, please include any travel itineraries, incident reports or police reports**

Trip Begin Date: _____ Scheduled Trip End Date: _____ Injury sustained during: ☐ Work Activity ☐ Pleasure Activity
Amount of BTA Insurance claimed: $_____ Date of Accident: _____ Time of Accident (hr, min) ___:___ ☐ AM ☐ PM
Place of Accident: _____ Fully describe the circumstances of the Accident and nature of Injuries, if known: (Include incident/police reports as available; attach separate sheet, if necessary) _____

EMPLOYER CERTIFICATION

I hereby certify that the information provided on the Employer Statement 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.

_____ Employer _____ Address

_____ Signature _____ Date _____ Their Authorized Representative (Please print)

( ) _____ Telephone Number _____ E-mail Address ( ) _____ Facsimile Number

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Part II - Beneficiary's Statement

- Release of claim forms is not an admission of coverage; or that a claim is payable.
- The Company reserves the right to require or to obtain further proof of information, if necessary, upon claim review.
- Please verify if employee may have qualified, was enrolled and covered, for any other group benefits through The Hartford and submit a claim accordingly. If uncertain, please contact the group policyholder/employer for assistance.

GROUP POLICYHOLDER/EMPLOYER NAME:		
Name of Insured/Employee:	Date of Birth:	Social Security Number:

Deceased's Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed ☐ Partnered

If known, please indicate the manner of death below:

☐ Natural ☐ Accident ☐ Homicide ☐ Suicide ☐ Pending/Undetermined/Unknown Cause (if known):_____

Please provide a copy of the death certificate with your submission. If not available, please submit as soon as possible.

If the death was due to an accident, please note there is an additional questionnaire to complete on page 4.

DEATH BENEFIT PAYMENT OPTION

The Hartford offers payment options outlined below. The Safe Haven Program is an option available in all states, except AK, for benefits of $10,000 or more ($15,000 or more for MN residents). Please know if you do not make an election below, we will pay your benefits into the Safe Haven Program, except in CT, FL, MN, NC and NY, as an election for these states must be completed in order to pay into the Safe Haven Program. The Safe Haven Program option is not available for benefits payable under the Voluntary Accidental Death plan, Accidental Dismemberment plan, or the Business Travel Accident plan. Further, the Safe Haven Program is not an option for minor beneficiaries, estates or trusts.

Please review the Safe Haven Program Interest and Disclosure Notice.

☐ I would like the full amount of the insurance proceeds payable to me in a single distribution, into the Safe Haven Program. I have reviewed and understand the Safe Haven Program Interest and Disclosure Notice that has been provided to me.

☐ I would like the full amount of the insurance proceeds payable to me by check.

Beneficiary Name: (print)	Date of Birth:	Relationship:
Citizenship: ☐ U.S. citizen ☐ U.S. resident ☐ Non-resident alien (Request a W-8BEN)		
Complete Mailing Address: (Number & Street)	Beneficiary's Social Security Number or Estate /Trust Tax ID:	
(City, State & Zip Code)	E-mail address:	

Personal Cell Phone: (_____)_____ Home Phone: (_____)_____

May we have your authorization to communicate benefit information and/or request information by e-mail? ☐ Yes ☐ No;
or leave confidential information on your personal cell phone? ☐ Yes ☐ No Please initial here:_____to confirm your elections

By signing below:

(1) I Hereby Certify and Agree that I have read and understand the IMPORTANT NOTICE page within this claim form.

(2) I Hereby Certify that the information provided on this Beneficiary Statement is true and complete, to the best of my knowledge.

(3) I Understand and Agree that if I receive claim proceeds which are not due to me, I will reimburse The Hartford.

Signature:	*Date:*
X	

Group Life and/or Accidental Death Claim Form for EMPLOYEE or DEPENDENT

THE HARTFORD

Claimant's Statement of Accidental Death (complete only if death was due to an accident)

- If death was due to an accident, death certificate must be submitted at time of claim
- If you do not know or have a response to a question, please indicate "Unknown"
- If the question doesn't apply, please indicate "N/A"

Group Policyholder/Employer Name: _____

Group Policy Number(s): Life/AD&D:_____ AD&D:_____ Business Travel Accident:_____

Name of Insured/Employee:		**Social Security Number:**
Name of Deceased: (if different from above)	Age:	Relationship to Employee: ☐ Spouse ☐ Child

Has a Workers' Compensation claim been filed? ☐ Yes ☐ No If "Yes," what is the status of the claim? _____

On what date did the accident happen? _____ Where did the accident happen? City: _____ State: _____

Please describe injuries received:

Did accident result in death? ☐ Yes ☐ No If "Yes," on what date? _____

If injury was sustained while traveling on policyholder/employer business, please complete the following:
Trip Begin Date: _____ Scheduled Trip End Date: _____

Injury was sustained during: ☐ Work Activity ☐ Pleasure Activity

For all accident claims, please complete the following:

Describe in detail how the accident happened:

Name and address of law enforcement agency involved: *(Please submit copy of Police Accident Report and/or Case Number)*

List name/address/phone number of all physicians consulted for the injury/death:

List name/address/phone number of all hospitals consulted:

Did the deceased have any chronic disease or physical defect or deformity? ☐ Yes ☐ No If "Yes", describe in detail:

Was an autopsy performed? ☐ Yes ☐ No If "Yes," provide name/address/telephone number of coroner, if known:

Was an inquest held? ☐ Yes ☐ No If "Yes", verdict:

Please complete and sign the Authorization to Obtain and Disclose Information on page 6

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, Alabama, California, Colorado, Florida, Kentucky, Maine, Maryland, New Jersey, New York, Ohio, Oklahoma, Oregon, Pennsylvania, Puerto Rico, Tennessee, Virginia 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 statement 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 Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

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 information to obtain or amend insurance coverage or to make a 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 and 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 information 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 Ohio: Any person who, with intent to defraud or knowing 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.

For residents of Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

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 thereto that the insurer relied upon 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.

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.

The statements contained in this form are true and complete to the best of my knowledge and belief.

Signature _____ Date _____

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I allow all doctors, hospitals, other health care providers, pharmacy, pharmacy benefit managers, government agencies (including, but not limited to, Federal, State or Local, and the Social Security Administration and Veterans Administration), insurers, employers, financial institutions, educational institutions, health plans, health insurance carriers, policyholders, contract holders, vendors, health and benefit insurers and administrators or their successors ("Records Holders") to give to and discuss with The Hartford and its representatives, the following personal, private, or privileged information, records, or documents related to:

Insured's Name (Please Print)	Date of Birth	XXX-XX- Last 4 Digits of Social Security Number

Any and all medical information or records, including medical histories, physical, mental, or diagnostic examinations, pharmaceutical records, and treatment notes, and including information regarding HIV/AIDS, communicable diseases, alcohol or substance abuse, and behavioral or mental health (but excluding psychotherapy notes); information on any insurance coverage and claims filed, including all records and information related to such coverage and claims; and academic transcripts. The information obtained by use of this Authorization will be used by The Hartford (including subsidiaries and affiliates) for the purpose of evaluating and administering my claim(s) for benefits. Such information shall be referred to herein collectively as “My Information.”

I understand that once My Information has been disclosed to The Hartford as permitted under this Authorization, it may be re-disclosed by The Hartford as permitted by law or my further authorization. Without limiting the foregoing, I authorize The Hartford to use or disclose My Information (i) to my employer for: a) responding to complaints by me or my representative relating to benefits; b) responding to any litigation, agency or regulatory proceeding, grievance, alternative dispute resolution, or lawful subpoena (including regarding employment claims); c) fulfilling fiduciary obligations under my benefit plan; or (d) claim, other audits or benefit program reviews; (ii) to administrators or other service providers, including health and wellness vendors, of my employer’s benefit plan(s) and/or programs, including leave management, for plan, benefit, or program related functions or data aggregation and analysis; (iii) to any electronic claim systems or programs or third party vendors used for claims administration or processing or to any insurance broker to carry out functions related to my benefit plan/program or claim; (iv) to any health care professional who has treated or evaluated me or who may do so; (v) to other persons or entities performing business, medical, or legal services related to my claim; (vi) for other insurance, reinsurance or analytical purposes, including workers’ compensation insurance, Social Security Disability insurance, or subrogation or reimbursement purposes; (vii) as may be lawfully required; (viii) as may be reasonably necessary to protect the personal safety of others or myself; (ix) as may be reasonably necessary to respond to regulatory or similar complaints; and (x) as may be reasonably necessary to prevent or detect perpetration of a fraud. I understand that My Information disclosed to The Hartford and re-disclosed to others could include information regarding alcohol and substance abuse, HIV/AIDS, other communicable diseases, and behavioral and mental health records.

I understand that once My Information is given out as allowed in this form, federal privacy laws may not protect it and it may be re-disclosed by The Hartford. I also understand that information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient. The Authorizations set forth herein expire two years from the date listed below, or upon my written revocation, if earlier, except as may be reasonably necessary to prevent or detect perpetration of a fraud, adjudicate a benefits claim, respond to regulatory or similar complaints, or protect the personal safety of others or myself. I understand that a revocation of this Authorization is not effective to the extent that any of my Record Holders or The Hartford has relied on this Authorization or to the extent that the Hartford has a legal right to contest a claim for benefits or to contest the policy. If I do not sign this Authorization, The Hartford may not be able to review my claim and determine whether I am eligible for benefits. This may result in a delay or denial of my request for benefits.

The Information released under this Authorization can be submitted to The Hartford electronically, by phone or fax, or by mail. I agree that a copy of this Authorization may be treated as a signed original. I understand that I am entitled to receive a copy of this Authorization upon request. If there is a conflict between a prior request for restriction on the disclosure of My Information and this Authorization, this Authorization will control.

Signature of Claimant or Legal Representative	**Date**	**Name and Relationship to Claimant** *(if signed by Legal Representative)*

Form must be signed and dated

Safe Haven Program Interest and Disclosure Notice

Your Proceeds: The full amount of the insurance proceeds payable to you will be distributed, in a single distribution into the Safe Haven Program. This is a draft account, not a checking account. Checks are drafts drawn on banks. Under the Safe Haven Program, your money is not held in a bank. It is held in The Hartford's general account. As a result, your drafts are drawn on The Hartford and are only payable through the Bank of New York Mellon, 500 Ross St., Room 1380, Pittsburgh, PA 15262. The draft kit mailed to you provides access, at any time, to part or all of these funds by writing one or multiple drafts, which you can use like personal checks. You understand that after the distribution into The Safe Haven Program, which constitutes full payment of the insurance proceeds, any claim that you may pursue against The Hartford will relate to the undertaking between you and The Hartford as to The Safe Haven Program, not the insurance policy. Original claim settlement options are not preserved.

Interest Earned: Effective 4/1/23, the rate of interest credited on assets in the Safe Haven Program is 1.0%. The Hartford, in its sole discretion, determines the credited interest rate and can change the rate at any time. The Hartford credits interest on your money compounded and credited to you on the last day of each month. Interest is earned on the funds in Safe Haven from the date your claim under the insurance policy is settled and the full amount payable to you has been distributed, in a single distribution, through the Safe Haven Program. Interest will be available for withdrawal on the day it has been credited. The Hartford in its sole discretion, determines the credited interest rate. The interest rate is based, in part, upon the analysis of interest rates credited on similar short-term products. In determining the interest rate, we also factor in the impact of The Hartford's profitability, general economic trends, competitive factors and administrative expenses. The Hartford will earn investment income on Safe Haven assets. The difference between the investment income earned on the Safe Haven assets and the interest rate credited to our customers participating in the Safe Haven Program will provide The Hartford with a profit and cover the expenses we incur.

Tax Reporting and Considerations: The interest earned on your account is considered taxable income. The Hartford is required by law to report the interest amount annually to you and the Internal Revenue Service (IRS). If you have any tax related questions, please consult with a tax advisor.

Not FDIC Insured: Your money in the Safe Haven Program is not held in a bank account and is not insured by the Federal Deposit Insurance Corporation; nor is it backed or guaranteed by any federal or state government agency. Your money is held in the general account of the applicable issuing company of The Hartford and your ability to withdraw your money is based on the claims paying ability of the issuing company. In the event of insurer insolvency, your state's Insurance Guaranty Association provides some coverage of assets in the Safe Haven Program. Since coverage varies by state, we advise you to contact your state's guaranty association for information about coverage and limitations. You can find the link to their website at www.nolhga.com - the National Organization of Life and Health Insurance Guaranty Associations (phone: 703-481-5206).

Minimum Balance Requirement: If the balance of your proceeds drops below $750, we will mail you a check for the balance of your funds, the accrued interest, and a closeout statement on the last day of the month.

Statements: Each quarter you will be mailed a statement showing withdrawals, interest credited, cleared drafts, current interest rate, and any other activity. Interim monthly statements will only be provided upon request or when there are new transactions posted or credited to your proceeds other than earned interest.

Fees and Withdrawal Restrictions: The Safe Haven Program does not charge any fees against your account. There are no restrictions for withdrawal frequency or minimum withdrawal amounts.

Account Inactivity: We may be obligated to transfer (escheat) your money in the Safe Haven Program to your state if no activity occurs in the account within the time period specified by your state's unclaimed property laws. The Hartford understands the importance of customer communication and will make reasonable, customary attempts to research and contact you seeking your response prior to any such transfer.

Beneficiary Designation: You can specify primary and contingent beneficiaries for your Safe Haven proceeds who will receive any remaining funds in the event of your death.

Payment Interruption: In the event of insolvency of the issuing company, a lengthy delay is possible before you can get your money.

Customer Service: For additional information and answers to any questions about the Safe Haven Program, you can reach our Customer Care Center toll free at 1-800-918-2335. Or write us at The Hartford, Safe Haven Program, P.O. Box 5005, Hartford, CT 06102.

FOR FURTHER INFORMATION, PLEASE CONTACT YOUR STATE DEPARTMENT OF INSURANCE