

**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

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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

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**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  
ID# (469)417-1111

**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	f FAST Stage: _____   f MMSE Score: _____ f Date of initial (first ever) diagnosis: _____
F Advanced Multiple Sclerosis	MRI, CSF, EP, neurological exam	f Has the condition produced at least 2 neurological abnormalities? F Yes F No

GROUP