



Hartford Life

HARTFORD LIFE INSURANCE COMPANY
HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
PROOF OF DEATH(Group Life Insurance)

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

STATEMENT OF EMPLOYER

Form section for employer information including: Full Name of Employee, Employee Social Security No., Last Residence, Branch or Subsidiary, Date of Birth, Date Employed, Policy Number, Date of Death, Effective Date of Employee's Insurance, Date Last Actively at Work, Reason employee did not return to work after last day worked, Have premiums been paid to date for this insured?, Occupation, Classification.

AMOUNT OF INSURANCE BEING CLAIMED section including: Basic Life, AD&D Basic, Supplemental Life, AD&D Supplemental, Benefit based on previous year's W-2?, Do age reductions apply?, Was an application for conversion completed?, Date insurance was discontinued, if not in force, Rate of basic earnings on date last worked, Do the earnings include commissions or bonuses?, Regular hours scheduled to work, Was claim for Long Term Disability or Waiver of Premium submitted to Hartford Life prior to date of death?, Was an LBO/Accelerated Death Benefit or Waiver of Premium claim ever approved by the prior carrier?.

Note: Changes in amounts of coverage, or increases in coverage, may not apply if the employee was absent from work due to illness or injury on the effective date. Changes in amounts of coverage and increases are deferred until the employee returns to active full-time work. If the employee elected increases in coverage during the past two years, and the amount being claimed reflects the increases, attach copies of the election form.

State name & amounts of other insurance, if any.

Mail benefit check to: Employer Address section including checkboxes for Employer and Beneficiary with copy to Employer.

PLEASE SEE REVERSE SIDE OF FORM FOR EMPLOYER CERTIFICATION

BENEFICIARY CERTIFICATION (Note: If any beneficiary entitled to benefits is deceased, obtain official copy of Death Certificate.)

I hereby certify that the information provided by me in this Proof of Death form is true and complete to the best of my knowledge and belief, and I have read and understand the statements on the reverse side. Pursuant to IRS Form W-9, Request for Taxpayer Identification Number and Certification, I certify under penalties of perjury that the Social Security Number on this form is correct. I am not subject to IRS back-up withholding.

Beneficiary information form including: Name of Beneficiary, Date of Birth, Relationship to Employee, Address of Beneficiary (No., Street, City or Town, State/Zip Code), Signature of Beneficiary, Social Security Number.

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