Group Life and Accidental Death Claim Forms for Employee or Dependent

IMPORTANT INSTRUCTIONS FOR COMPLETING CLAIM FORM(S)

To the Employer and Employee/Beneficiary, as applicable.

We know this is a difficult time, and we want to assist you in filing your claim as quickly as possible. Please read these important instructions regarding completion of these forms. Also, please read the “Important Notice” on page 5.

The information below constitutes a complete claim filed with The Hartford for purposes of claiming Basic, Supplemental and Dependent coverage.

Part I - Employer’s Statement (needed for both, Life or Accidental Death claims)

- ☐ Form is to be completed in its entirety and signed by the Official Representative of the Employer/Plan
- ☐ A certified copy of the Death Certificate stating cause and manner of death must be attached to this form.
- ☐ Proof of salary as defined in the Policy (attach W2 or commissions, if applicable)
- ☐ Submission of claims on any voluntary or contributory Life plans, including Dependent coverage, must include copies of the enrollment forms and history to show timely enrollment.
- ☐ 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 Employer/Plan shall certify to that fact on the claim form.

Part II - Beneficiary Statement (needed for both, Life and Accidental Death claims)

- ☐ If more than one beneficiary, each beneficiary can either sign and date one form, or each can complete separate forms, showing their current address, date of birth and Social Security Number.
- ☐ All beneficiaries must elect a Payment Option (page 3). Please refer to the Safe Haven Interest Rate Notice and the Safe Haven Program Terms & Conditions pages of this form.
- ☐ **If claiming Accidental Death please furnish, if available, police or motor vehicle Accident/Incident reports, autopsy/ toxicology or other pertinent information regarding the claim.**

Miscellaneous - All Claims

- ☐ If the claim proceeds are payable to an Estate, Part II must be completed by the Executor or Administrator of the Estate. An official certificate of such person’s legal appointment and qualification must be attached to this form. Please include the Estate Tax Identification Number. If none available, please explain.
- ☐ If any designated beneficiary is a minor, Part II must be completed by a custodian or guardian. Include the minor’s social security number, also, please include a copy of the minor’s birth certificate. An official certificate of the guardian’s legal appointment and qualification of the minor’s **estate or property** must also be included, if applicable.
- ☐ If claim is for a dependent child enrolled in an accredited school of higher learning, submitted documents should include a student enrollment verification form executed by the school, applicable if required under the Policy.
- ☐ Foreign Death - Include both the Official Death Certificate and the Death of American Citizen Abroad form. Please note that additional documents may be required upon claim review.

Submit claim by mail to: The Hartford
Group Life Claims
P.O. Box 14299
Fax to: 1-866-954-2621
E-Mail to: gbclaimcslife@thehartford.com

Release of claim forms is not an admission of coverage under a policy for an employer, group or organization.

The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries.

All support services offered through Beneficiary Assist are provided by ComPsych®, a national leader in employee assistance programs. ComPsych is not affiliated with The Hartford. Neither The Hartford nor ComPsych® provide financial or legal advice.

HARTFORD LIFE INSURANCE COMPANY
HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

PROOF OF DEATH FORM (Group Life Insurance)
EMPLOYEE or DEPENDENT

Mail forms to: The Hartford
Group Life Claims
P. O. Box 14299
Lexington, KY 40512-4299
1-888-563-1124 Fax: 1-866-954-2621
E-Mail: gbclaimcslife@thehartford.com

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

Group Policy Numbers:
Life/ AD&D:____________ Voluntary AD&D:____________ Group Travel:____________

Employer:

Name of Insured /Participant:

Social Security Number:

Insured's address: (Street, City, State & Zip Code)

Date of Birth:

Date of Death:

Branch/Location:

☐ Salaried
☐ Hourly

Date of Hire:

Effective date of employee's insurance:

Premiums paid to date? ☐ Yes ☐ No

Occupation:

Classification

Provide 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):____________

Is there a Beneficiary Designation Card on file? ☐ Yes ☐ No If "Yes," a copy must be submitted

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

Basic Life:
$

Supplemental Life:
$

Include AD&D amount(s) only if death was due to an accident

AD&D Basic:
$

AD&D Supplemental:
$

Coverage claimed above, reflect age reduction(s)? ☐ Yes ☐ No

Date insurance was discontinued or not in force ____________

(Employee's earning as defined in the policy. Attach W-2 if applicable)

Rate of earnings used to calculate benefit amount: ____________
☐ Hourly ☐ Weekly ☐ Monthly ☐ Annually

Regular hours scheduled to work: (if applicable) ____________

Effective date of above reported earnings: ____________

Do the earnings include commissions or bonuses? ☐ Yes ☐ No

Indicate if any of the following apply to this Employee:
☐ Applied for Conversion
☐ Has been approved for Long Term Disability
☐ Has been approved for LBO/Accelerated Death Benefits by prior carrier
☐ Has been approved for Waiver of Premium by 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 employee returns to active full-time work. If the employee elected increases in coverage during the past two years, the amount being claimed reflects the increase, attach copies of the election forms.

State name and amounts of other insurance policy(ies), if any.

DEPENDENT INFORMATION - ONLY COMPLETE FOR DEPENDENT CLAIM

Full Name of Deceased Dependent	Deceased's Social Security Number	Date of Birth	Date of Death	Relationship to Employee

Last Residence: (Number, Street, City or Town, Zip Code)

Is Employee Actively at Work? ☐ Yes ☐ No
If no, complete date last worked and reason above

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 Enrollment verification from school.

Was dependent child incapacitated? ☐ Yes ☐ No

AMOUNT OF INSURANCE BEING CLAIMED FOR DEPENDENT

Basic Life:
$

Supplemental Life:
$

Include AD&D amount(s) only if death was due to an accident and applicable under the Policy

AD&D Basic:
$

AD&D Supplemental:
$

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 Dependent:
☐ Applied for Conversion
☐ Has been approved for LBO/Accelerated Death Benefits by prior carrier
☐ Has been approved for Waiver of Premium by prior carrier

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 Hartford Life Insurance Company or Hartford Life and Accident Insurance Company and/or its representative.

Employer ____________ Address ____________

Signature ____________ Date ____________ Their Authorized Representative: (Please print) ____________

( ) Telephone Number ____________ E-mail address ____________ ( ) Facsimile Number ____________

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

PART II - Beneficiary's Statement

Name of Deceased: ______________________ **Policy Number(s):** ______________

Claim Number (if known): ______________

Under penalties of perjury, I certify that:

(1) the number shown on this form is my correct taxpayer identification; and

(2) I am not subject to a back-up withholding, because, (a) I am exempt from back-up withholding; or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest and dividends; or (c) the IRS has notified me that I am no longer subject to back-up withholding; and

(3) I am a U.S. person (including a U.S. resident alien).

Certification Instructions: You must cross out item (2) above, if you have been notified by the IRS that you are currently subject to back-up withholding, because, you have failed to report all interest and dividends on your tax return.

By signing below:

(1) **I Hereby Certify and Agree** that I have read and understand the IMPORTANT NOTICE on page 5 of this claim form package.

(2) **I understand and Agree** that payment of the claim proceeds according to any alternate mode of settlement specified in the policy will only be made if the Company receives a written request for such alternate method of payment from me prior to the payment of the claim proceeds.

DEATH BENEFIT PAYMENT OPTION

The Hartford offers various payment options to you as described below. Please know if you do not make an election below, we will pay your benefits via the Safe Haven Program, except in AK, NY, FL, CT or NC. The Safe Haven program option is not available for benefits less than $10,000 or when payable under the Accidental Dismemberment plan. Please review the Safe Haven Program Terms & Conditions and the disclosure on the interest rate earned.

☐ 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 Terms & Conditions that have been provided to me.

☐ I would like the full amount of the insurance proceeds payable to me in a single distribution, via 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)	Telephone Number: Day: ( ) Evening: ( )

Personal Cell Telephone Number: ( ) __________ May we have your authorization to leave confidential medical and benefit information on your personal cell phone? ☐ Yes ☐ No and/or request this by e-mail: ☐ Yes ☐ No Please initial:________to confirm your election

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

Signature: X	Date:	E-mail address:

DEATH BENEFIT PAYMENT OPTION

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Complete Mailing Address: (Number & Street)	Beneficiary's Social Security Number or Estate /Trust Tax ID:
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Personal Cell Telephone Number: ( ) __________ May we have your authorization to leave confidential medical and benefit information on your personal cell phone? ☐ Yes ☐ No and/or request this by e-mail: ☐ Yes ☐ No Please initial:________to confirm your election

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

Signature: X	Date:	E-mail address:

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

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

INSTRUCTIONS: Complete this form if you are applying for death benefits due to an Accident.
If a question does not apply, please mark "N/A."

GROUP POLICYHOLDER/EMPLOYER NAME: ____________

Name of Insured Employee/Participant:	**Social Security Number:**	**Policy Number(s):** Life AD&D
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? ____________

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:

MEDICAL RELEASE AUTHORIZATION

To: Any health care provider, employer, benefit plan, insurer, service provider, financial institution, consumer reporting agency, educational institution, or Federal, State, or Local Government Agency, including the Social Security Administration and Veterans Administration. **I AUTHORIZE** you to disclose to The Hartford a complete copy of any and all of the following personal or privileged information, records, or documents relative to:

Insured's Name (Please print)	Date of Birth	Last 4 Digits of Social Security Number

Any and all medical information or records, including x-ray films, medical histories, physical, mental, or diagnostic examinations and treatment notes, and including information regarding HIV/AIDS, communicable diseases, alcohol or drug abuse, and mental health work information and history, including job duties, earnings, personnel records, and client lists information on any insurance coverage and claims filed, including all records and information related to such coverage and claims credit information, including credit reports and credit applications other financial information, including pension benefits and bank records business transactions billing, invoice, and payment records academic transcripts and information concerning Social Security benefits, including monthly benefit amounts, monthly payment amounts, entitlement dates, and information from my Master Beneficiary Record. The information obtained by use of this Authorization will be used for the purpose of evaluating and administering my claim for benefits and/or leave request. Such information shall be referred to herein collectively as "My Information." I understand I have the right to revoke this Authorization for future disclosures, except to the extent action has been taken in reliance upon this Authorization. I must revoke this Authorization in writing directly to The Hartford.

I UNDERSTAND that information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient. I understand that I have the right to revoke this Authorization for future disclosures The Hartford may make,unless The Hartford has taken action in reliance upon this Authorization. I must revoke this Authorization in writing directly to The Hartford. I understand that my medical treatment or payment for medical benefits cannot be conditioned on my allowing The Hartford to re-disclose My Information. The authorizations set forth herein expire two years from the date listed below, or upon my revocation, if earlier, but will not exceed the term of my coverage under the policy(ies) or benefit plan or program, except as may be reasonably necessary to prevent or detect perpetration of a fraud or protect the personal safety of others. I understand that I am entitled to receive a copy of this Authorization upon request. A photocopyor facsimile of this Authorization shall be as valid as the original. If there is a conflict between a prior request for restrictionon the disclosure of My Information and this Authorization, this Authorization will control.

Signature of Beneficiary or Personal Representative	Date	Relationship to Insured

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

INTEREST RATE NOTICE

The Safe Haven® Program

Effective 11/01/18, the rate of interest credited on assets in the Safe Haven Program is **0.6) %***

Safe Haven is intended to provide our customers with a convenient means for paying for their immediate needs and to allow them time to decide how to use the remaining balance of their insurance or annuity proceeds. Interest is paid from the date your claim is settled to the date you withdraw your funds.

Interest is compounded daily and credited to your account on the last day of each month. Interest will be available for withdrawal the day it has been credited.

If you elect to participate in The Hartford's Safe Haven program, your insurance or annuity proceeds ("Safe Haven assets") will be held in The Hartford's general account.

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.

***The Hartford, in its sole discretion, determines the credited interest rate and can change the rate at any time. The current rate of interest will be displayed on your Program statement or you can call Customer Service at 1-800-918-2335. 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 interest rate is effective 11/01/18; all other information and representations herein are as of 10/15/11.

Printed in U.S.A. ©2018 The Hartford, Hartford, CT 06155

Terms and Conditions

This constitutes a supplemental contract.

The Safe Haven Program

The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries, including issuing companies Hartford Fire Insurance Company, Hartford Life Insurance Company, Hartford Life and Annuity Insurance Company, Hartford Life and Accident Insurance Company, and Hartford Life Group Insurance Company. Hartford Life Insurance Company and Hartford Life and Annuity Insurance Company are acting as the administrator of the Safe Haven program for Time Insurance Company, Union Security Life Insurance Company of New York and Union Security Insurance Company. Refer to the original policy for the appropriate insurer.

A. Your Proceeds

The full amount of the insurance proceeds payable to you has been 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. Please note that certain merchants as part of their business protocol, may screen a customer's check or draft payment for acceptance using a variety of factors (e.g. customer's check writing history) and/or utilize third party check verification services. A merchant may consider the nature of a draft account as one factor in their screening process.

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.

B. Interest Earned

The Hartford credits interest on your money compounded daily 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.

Your money in the Safe Haven Program is held in The Hartford's general account. 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.

C. 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 the interest earned in Safe Haven during the year is $10.00 or more and you are a U.S. Person, a form 1099-INT will be mailed to you at the end of the year.

If you are a Foreign Person, the interest amount is subject to different reporting requirements.

Choosing and keeping a retained asset account may have tax implications. Please consult with a tax advisor with any tax questions related to your account.

D. 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 as listed above.

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).

E. 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. Certain accounts that are scheduled to receive future deposits are exempt from this requirement; please contact customer service with any questions.

F. 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.

G. Fraud Prevention & Your Responsibilities

You should exercise reasonable care and promptness in examining your statement and notify customer service immediately if you question a particular transaction. Failure to report any questionable transactions in a timely manner may result in loss of funds.

You should keep your Safe Haven draft book in a safe and secure location. In the event you lose possession of your Safe Haven draft book, you must notify customer service. Failure to report a lost or stolen draft book in a timely manner may result in loss of funds.

You are responsible to provide a valid W-9 form for name, signature and tax identification number verification. Failure to do so may impact transaction processing, security authentication and our mutual efforts to prevent fraud.

In the event of reasonably suspected or known fraud, The Hartford reserves the right to freeze funds in the account pending timely receipt of required documents, investigation and resolution. To the extent required by applicable state law, The Hartford is responsible for any unauthorized use of the Safe Haven account and will make you whole in the event of an unauthorized use, including among other events, payment made on a forged instrument.

H. Cleared Drafts

Cleared drafts will be retained by the Bank of New York Mellon and will not be returned to you. A copy of cleared drafts will be printed on your statement.

You may also obtain a copy of a cleared draft by contacting Customer Service.

I. 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.

J. Deposits

You may not make deposits into Safe Haven. Only interest earned and insurance proceeds distributed to you may be deposited.

K. Ending Participation in Safe Haven

You can choose from any of the three following options to terminate your participation with Safe Haven:

- Write a draft for the entire balance;
- Call Customer Service and request that your participation be terminated;

- Write a letter asking that your participation be terminated and mail it to:

  The Hartford
  Safe Haven Program
  P.O. Box 5005
  Hartford, CT 06102

Please include your name, account number, address, signature, and a phone number on all correspondences.

L. 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. Safe Haven understands the importance of customer communication and will make reasonable and customary attempts to research and contact you seeking your response prior to any such transfer. It is important that you keep your name, address and contact information current.

Examples of account activity that indicate your desire to continue participation may include:

- Contacting customer service to update or confirm your contact information
- Viewing account activity and other information online at http://www.thehartford.com
- Calling our automated phone system 24/7 at 1-866-414-8181 for basic information
- Writing a draft to pay bills, make purchases, get cash, invest, et cetera.

As always, if you need assistance with any of these options then call customer service. We are here to serve you.

M. Changes in Terms and Conditions; Acceptance

The Hartford reserves the right to change the terms and conditions of this Safe Haven program. You will be informed in your quarterly statement that changes have been made. Your continued usage of the services provided through Safe Haven constitutes acceptance of these terms and conditions.

In addition, The Hartford reserves the right to terminate your participation at any time.

N. Address Change

Please notify us of any change of address. Failure to provide new address information could cause a delay in your receipt of quarterly statements and year-end tax forms.

O. Assignments

Your Safe Haven is not transferable.

P. 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. We request that you provide us with beneficiary information prior to establishing your account. For each named beneficiary, we request their address, social security number, date of birth, phone number and percent distribution. You may easily obtain a beneficiary designation form at any time by contacting Customer Service. Your beneficiary designation will be effective only if you execute a beneficiary designation form and receive our letter of confirmation.

If you do not designate a beneficiary, The Hartford, upon notification of your death and receipt of a valid death certificate and required documents, will close your account and pay any remaining funds to your estate.

Q. Authorized Persons

You, the accountholder, are the only contact authorized to act on this account unless the appropriate legal authorization is established (e.g. power of attorney, guardianship, or conservatorship paperwork) and the required program documents are completed and returned. Program documents will be supplied upon your request and will require that you provide the proper identification information for any party being granted financial authorization, including their name, address, phone number, social security number, date of birth and signature. Upon receipt of legal and program documents, a review will be performed to determine authorization and you will be provided a confirmation of processing.

R. Payment Interruption

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

S. Customer Service

For additional information and answers to any questions, you can reach our Customer Care Center toll free at 1-800-918-2335. Or write us, including your name, account number, address, signature, and phone number, at:

The Hartford
Safe Haven Program
P.O. Box 5005
Hartford, CT 06102

For Private Express Mail Carriers:

The Hartford
Safe Haven Program
1 Griffin Road North
Windsor, CT 06095-1512

Automated services provide basic transactions 24 hours a day, 7 days a week by calling 1-866-414-8181. This toll free number is also located on your quarterly statement.

FOR FURTHER INFORMATION, PLEASE CONTACT YOUR STATE DEPARTMENT OF INSURANCE.

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We recommend that you consult a financial advisor regarding investment options.

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SHTERMS-BW 11-01-2013 RPS 114880 13-0069 Printed in U.S.A. © November 2013