Business Travel Accident
Death, Dismemberment, Injury and/or Sickness
Claim Form

THE HARTFORD

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 Business Travel Accident benefits.

Part I – Employer's Statement (for All claim filings)

☐ Form is to be completed in its entirety and signed by the Official Representative of the Employer/Plan.

☐ If filing is for a death claim, a certified copy of the Death Certificate stating cause and manner of death must be attached to this form.

☐ If filing is for a death claim, the claim 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 – Claimant's Statement (for All claim filings – also refer to Miscellaneous section)

☐ Must be completed by claimant or beneficiary when claiming benefits for any type of loss.

Part III – Insured/Beneficiary Statement

☐ If more than one beneficiary, the beneficiaries may sign and date one form, or each may complete separate forms, showing their current address, date of birth, and Social Security Number.

Part IV – Attending Physician's Statement (for Dismemberment/Sight/Hearing/Speech/Injury/Sickness claims)

☐ Complete the top portion of the Attending Physician's Statement, pages 7 and 8, for above losses. Provide both pages to your physician and request that they be completed and returned to The Hartford.

Miscellaneous – All Claims

☐ Please sign the Medical Release of Information Authorization, page 6.

☐ Furnish, if available, police, motor vehicle Accident/Incident reports, autopsy/toxicology, trip itinerary and other pertinent information regarding your claim.

☐ If the claim proceeds are payable to an Estate, Part II and/or Part III must be completed by the Executors or Administrators 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 beneficiary is a minor, part II and/or III 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.

☐ 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
Lexington, KY 40512-4299
Fax to: 1-866-954-2621
E-Mail to: gbclaimcslife@thehartford.com
Phone: 1-888-563-1124

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

Business Travel Accident
Death, Dismemberment, Injury and/or
Sickness Claim Form

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

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PART I – EMPLOYER'S STATEMENT – TO BE COMPLETED FOR ALL CLAIMS

Policy Number:	Employer Name:		
Name of Employee:		Employee DOB:	Employee Social Security Number:
Employee Address (Street, City, State, & Zip Code):			
Branch/Location:	Occupation:		Regularly scheduled work week: _____hours per week
Date of Hire:	Trip Details (if applicable): Begin Date:_____ Scheduled End Date:_____		
FOR DEPENDENT CLAIM ONLY:			
Dependent Name:		Dependent DOB:	Dependent Social Security Number:
Dependent Address (Street, City, State, & Zip Code):			
Relationship to Employee: ☐Spouse ☐Dependent Child	If Dependent child benefits are claimed, was the child a full-time student? ☐Yes ☐No If Yes, as required, include enrollment verification from school.		Was dependent child incapacitated? ☐Yes ☐No
Benefits Claimed for:☐Death ☐Dismemberment ☐Injury ☐Sickness ☐Loss of Sight/Hearing/Speech ☐Paralysis ☐Loss of Use Amount Claimed: $_____			Injury sustained/Illness commenced during: ☐Work activity ☐Pleasure activity
Date of Death (if applicable):	Nature of Injury(ies) (if applicable):		Nature of Sickness (if applicable):
Date of Accident/Onset Date:	Time of Accident/Onset (hh:mm) ☐AM ☐PM	Place of Accident/Onset of Symptoms:	
Fully describe the circumstances of the Accident or Onset of Symptoms (Use a separate sheet of paper, if necessary):			

Injury/Sickness-related Benefit Information:
Please check each benefit requested as a result of the Covered Injury and/or Sickness. If any previous claims have been submitted for this Covered Loss, only check the benefits that are applicable to this new claim. Benefits listed below may not be included in all certificates/policies. Refer to the certificate available for all available benefits, limitations and exclusions. All relevant supporting documentation should be included with this claim submission to help prove the claim.

☐ Accidental Needle stick	☐ Extended Care Facility	☐ Occupational HIV
☐ Brain Damage	☐ Home Health Care	☐ Occupational Retraining
☐ Coma	☐ Hospital Indemnity	☐ Post-Traumatic Stress Disorder
☐ Cosmetic Disfigurement/Severe Burn	☐ Occupational Hepatitis	☐ Reconstructive Surgery

Is there a Beneficiary Designation on file? ☐ Yes ☐ No If Yes, please attach and return with this claim form.
Are there any absolute assignments on file? ☐ Yes ☐ No If Yes, please explain:

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

EMPLOYER CERTIFICATION – TO BE COMPLETED FOR ALL CLAIMS (SIGNATURE REQUIRED)

I hereby certify that the information provided on the Employer's 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.

_____ _____
Name and Title of Employer's Authorized Representative Address

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

_____ _____
Signature of Employer's Authorized Representative Date

Business Travel Accident
Death, Dismemberment, Injury and/or Sickness
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Group Life Claims
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Lexington, KY 40512-4299
Fax: 1-866-954-2621
E-Mail: gbclaimcslife@thehartford.com

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PART II – CLAIMANT'S STATEMENT –TO BE COMPLETED FOR ALL CLAIMS

INSTRUCTIONS: Complete this form when applying for Death, Dismemberment, Injury and/or Sickness benefits. If a question does not apply, please indicate "N/A."

Policy Number:	Policyholder Name:	
Employee Name:	Employee DOB:	Employee Social Security Number:
Name of Deceased or Injured (if different from above):	Deceased/Injured DOB:	Deceased/Injured Social Security Number:
Address of Deceased/Injured *(Street, City, State, & Zip Code)* (if different from above):		Relationship to Employee: ☐ Spouse ☐ Child

Benefits Claimed for: ☐ Death ☐ Injury ☐ Sickness ☐ Dismemberment ☐ Paralysis ☐ Loss of Use ☐ Loss of Sight/Hearing/Speech

Nature of Injury(ies) (if applicable):	Nature of Sickness (if applicable):	
Date of Accident/Onset Date:	Time of Accident/Onset (hh:mm): ☐AM ☐PM	Place of Accident/Onset of Symptoms:

Fully describe the circumstances of the Accident or onset of symptoms (Use a separate sheet of paper, if necessary):

Name and address of law enforcement agency involved:	Case Number:

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

Prior to the incident, did the Employee/Deceased/Injured have any chronic disease or physical defect or deformity? ☐ Yes ☐ No
If "Yes," describe in detail:

List all Healthcare Providers consulted for care due to this injury/sickness/death:

NAME	ADDRESS	PHONE NUMBER	PERIOD TREATED
			From: To:
			From: To:
			From: To:

List all hospitals where confined for care due to this injury/sickness/death:

NAME	ADDRESS	PHONE NUMBER	PERIOD CONFINED:
			From: To:
			From: To:
			From: To:

PLEASE ATTACH COPY OF ITEMIZED HOSPITAL BILL, UB92 OR MEDICARE SUMMARY (if applicable)

Did accident result in death? ☐ Yes ☐ No If "Yes," on what date: _____
Was autopsy performed? ☐ Yes ☐ No If "Yes," provide name/address/telephone number of coroner, if known:

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

Claimant's Name:	Date of birth:	Relationship to Employee/deceased/ injured:
Claimant's Address: *(Street, City, State, & Zip Code)*		Claimant's E-mail Address:

Phone Numbers:
Daytime: (____) _____ Evening: (____) _____ Personal Cell Phone: (____) _____
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:

SIGNATURE OF PERSON COMPLETING THIS FORM:	DATE:

(Note: if other than beneficiary, attach appropriate legal documents substantiating your authority.)
Please sign and date the Medical Release of Information Authorization on page 6.

THE HARTFORD

PART III - Insured/Beneficiary Statement

Name of Insured: _____ **Policy Number(s):** _____

Claim Number (if known): _____

NOTICE: INSURED/BENEFICIARY LOCATED OUTSIDE THE UNITED STATES

For all insureds/beneficiaries located outside the United States, if stated under the policy or in an agreement, benefit payments will be made in U.S. dollars to the Policyholder, located in the United States, in trust for the sole use and benefit of the insured/beneficiary.

The employer will transmit the payment to the insured/beneficiary promptly.

Insured/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: X	Date:

NOTICE: INSURED/BENEFICIARY LOCATED OUTSIDE THE UNITED STATES

For all insureds/beneficiaries located outside the United States, if stated under the policy or in an agreement, benefit payments will be made in U.S. dollars to the Policyholder, located in the United States, in trust for the sole use and benefit of the insured/beneficiary.

The employer will transmit the payment to the insured/beneficiary promptly.

Insured/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: X	Date:

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

DISMEMBERMENT, SIGHT, HEARING, SPEECH, INJURY, AND OR SICKNESS FILING ONLY

PART IV – ATTENDING PHYSICIAN'S STATEMENT

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

Please print – Use a separate sheet of paper, if necessary (Physician's Certification on Page Two)

Name of Patient:	Date of Birth:	Social Security Number:	
Address:	City:	State:	Zip Code:

Nature of condition(s) resulting from the incident: *(Check all that apply)*
☐ Injury ☐ Sickness ☐ Dismemberment ☐ Paralysis ☐ Loss of Use ☐ Loss of Sight/Hearing/Speech

Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☐ No
If "Yes," by whom?

Is patient still under your care for this condition? ☐Yes ☐No If "no," provide date your services terminated:

Injury Information
If condition is result of injury, please provide information as noted below.

Provide a description of the injuries received by the patient in the accident, the primary diagnosis, and the affected body part(s):

Date of injury:	Date patient first examined by you for this injury:

What complications, if any, have arisen?

Had patient previously had medical attention for this injury? ☐ Yes ☐ No
If "Yes," by whom?

Was the injury described above, or itself, and independent of all other causes, solely responsible for the loss? ☐ Yes ☐ No
If "No," give the particulars of any contributing cause(s):

Was claimant under the influence of alcohol and/or other drugs at the time of accident or injury? ☐Yes ☐No ☐Unknown

Was surgery performed due to the injury? ☐Yes ☐No Date of surgery:_____
Name of surgeon:

Sickness Information
If condition is a sickness, please provide information as noted below.

Provide the primary diagnosis and description of the of the patient's symptoms:

Onset date:	Date patient first examined by you for this sickness:

What complications, if any, have arisen?

Had patient previously had medical attention for this sickness? ☐Yes ☐No If "Yes," by whom?

Hospital Information
Was the patient confined to a hospital due to the injury/sickness? ☐Yes ☐No If "Yes," please provide information as noted below.

Hospital Name:

Hospital Address:

Date of Admission:	Date of Discharge:	Reason for Hospitalization:	☐Inpatient ☐Outpatient

Hospital Name:

Hospital Address:

Date of Admission:	Date of Discharge:	Reason for Hospitalization:	☐Inpatient ☐Outpatient

Coma - Means complete unconsciousness with inability to respond to external or internal stimuli for a continuous period.
Did patient's injury/sickness result in a Coma? ☐Yes ☐No If "Yes," please provide information as noted below.

Date Coma Began:	Date Coma Ended:	If Coma has not ended, Current Duration (days):

Was the Coma confirmed by EEG? ☐ Yes ☐ No

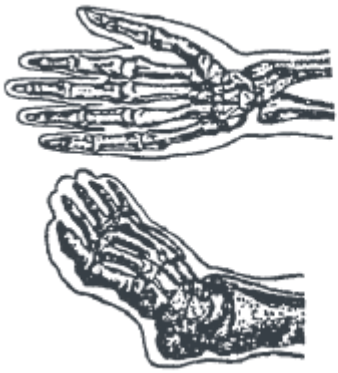
Note: Continue on next page for other losses.

ATTENDING PHYSICIAN'S STATEMENT – Cont. **Page Two**

Accidental Dismemberment, Paralysis and/or Loss of Use

If the injury described above caused an amputation or loss of body usage, is this amputation or loss irrecoverable? ☐Yes ☐No

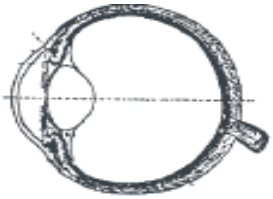
If "No," please explain: _____



Please indicate location of amputation or area of injury on the left side chart. Add any necessary comments below:

Loss of Sight

If the injury described above caused loss of sight, please provide copies of vision test and complete below.



Indicate best corrected visual acuity and/or area of injury as of date of last examination on _____ (date).

Right eye:	Corrected	Uncorrected
Left eye:	Corrected	Uncorrected

Is this loss of sight (due to injury) irrecoverable?
☐Yes ☐No

Loss of Hearing

In your medical opinion, has this patient sustained complete and irrecoverable hearing loss due to an injury?
☐Yes ☐No ☐Right ☐Left ☐Both

Please provide copies of auditory test results.

Loss of Speech

In your medical opinion, has this patient sustained complete and irrecoverable loss of speech due to an injury?
☐Yes ☐No

Please provide copies of speech test results.

Healthcare Provider Information and Certification

Healthcare Provider Name (please print):			
Specialty:	License Number:	EIN/Tax ID# or SSN:	
Street Address:	City/Town:	State:	Zip Code:
Telephone Number: ( )	Fax Number: ( )		
Physician's Signature:		Date:	