Please fax the completed questionnaire to:
New York State Nurses Association Benefits Fund
P.O. Box 12-430
Albany, NY 12212
Fax Number: 518-869-2317

ACCIDENTAL INJURY QUESTIONNAIRE

THE HARTFORD

Claimant Name: _____ Insured ID: _____

Email Address: _____

Personal Cell Telephone Number: ( ) _____ Alternate Telephone Number: ( ) _____

May we have your authorization to leave confidential medical and benefit information on your personal cell phone?
☐ Yes ☐ No

_____ _____
Signature Date

If your disability is the result of an injury or accident, please answer the following questions:

1. Date of Injury: _____

Location of injury or accident: Address of injury or accident:

- ☐ Home _____
- ☐ Work _____
- ☐ Private Property _____
- ☐ Retail Location _____
- ☐ Sporting Event _____
- ☐ Other Person's Residence _____
- ☐ Other _____

2. What were you doing at the time the injury occurred?

_____

3. Who or what contributed to your injury/accident?

_____

4. Did you file a lawsuit or a claim? ☐ Yes ☐ No

a. If a claim was filed, with whom? (provide name and address) _____

_____

b. If a lawsuit was filed, please send us a copy.

c. If no lawsuit or claim has been filed, do you intend to file a lawsuit or claim against any person or company?
☐ Yes ☐ No ☐ Unknown

Are you represented by an attorney? ☐ Yes ☐ No

Name of Attorney: _____ Telephone number of Attorney: ( ) _____

Address of Attorney: _____

Work Related Injuries or Accidents:

1. Were you working when the injury occurred? ☐ Yes ☐ No
2. Were you injured at your current place of employment or injured at a prior place of employment? ☐ Current ☐ Prior
3. Is your injury related to your work activities or work place? ☐ Yes ☐ No

If you answered "yes" to the above questions:

4. Did you file a Workers' Compensation Claim? ☐ Yes ☐ No

Workers' Compensation Carrier: _____

Workers' Compensation Claim Number: _____

Workers' Compensation Adjuster: _____ Telephone number of Adjuster: ( ) _____

What is the current status of your Workers' Compensation claim or lawsuit?

_____

Vehicle Accidents:

Were you driving or in a vehicle at the time of the accident? ☐ Yes ☐ No

Date of Accident:	How many vehicles were involved?

Please describe how and where (Street, City, State) the accident occurred:

Was a Police Report filed? ☐ Yes ☐ No

*** IF A POLICE REPORT WAS FILED, PLEASE ATTACH A COPY ***

Name of your Auto Insurance carrier:	Telephone Number of Insurance Carrier: ( )

Address of your Auto Insurance Carrier:

Your Auto Insurance claim number:	Do you have no fault coverage? ☐ Yes ☐ No

If the accident was caused by the negligence or wrong of a person, firm or corporation, please provide the following information:

Name of the Person / Company at fault:

Their Address:

Their Auto Insurance Company's Name:

Their Auto Insurance Company's Address:

Telephone number:
( )

Their Auto Insurance Claim Number:

What is the current status of your Auto claim or lawsuit?

Have you settled your claim or lawsuit? ☐ Yes ☐ No

If yes, please attach a copy of the settlement.

Signature - Please read the statement that applies to your state of residence and sign the bottom of the page.

With the exception of any source(s) of income reported above in this form, I certify by my signature that I have not received and am not eligible to receive any source of income, except for my disability benefits from this plan. Further, I understand that should I receive income of any kind or perform work of any kind during any period The Hartford has approved my disability claim, I must report all details to The Hartford, immediately. If I receive disability income benefits greater than those which should have been paid, I understand that I will be required to provide a lump sum repayment to the Plan. The Hartford has the option to reduce or eliminate future disability payments in order to recover any overpayment balance that is not reimbursed.

For residents of all states EXCEPT Arizona, California, Colorado, Florida, Kentucky, Maine, Maryland, New Jersey, New York, 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 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 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 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 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.

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

_____ _____

Signature Date

Electronic Funds Transfer (EFT) is our standard method of payment. When making our claim decision we may contact you to obtain your banking information.