

Group Benefits from The Hartford



State of Delaware

Policy # 071675



It's easy to file your Short-Term Disability Claim

Your **Short-Term Disability** program is an important part of your group benefits package.

If an illness or injury prevents you from working, ask your benefits representative to provide details about your **Short-Term Disability** benefits and when to file a claim.

Filing a Short-Term Disability Claim

To file a Short-Term Disability claim, simply call The Hartford's toll-free number:

866-945-7781

Or, file online at www.TheHartfordAtWork.com.

If you're absent from work due to an illness or injury, your benefits representative can advise you when to file your claim. If your absence is scheduled, such as a hospital stay, you may call prior to your last day of work.





Your Short-Term Disability administrator, The Hartford, makes it easier for you:

- 1 Call The Hartford¹ at this toll-free number to report your claim:
866-945-7781,
8:00 a.m. – 8:00 p.m. ET,
Monday-Friday.
You may also file a Short-Term Disability claim online at **www.TheHartfordAtWork.com**, 24/7.
- 2 Sign the attached wallet card and present it to your physician. If The Hartford needs additional medical information, your signature authorizes your physician to release that information.

When you follow these simple steps, The Hartford can provide you with prompt service.

¹ The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries, including issuing companies Hartford Life Insurance Company and Hartford Life and Accident Insurance Company. Policies sold in New York are underwritten by Hartford Life Insurance Company. Home Office of both companies is Simsbury, CT.

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Expertise without equal.
Benefits without burden.

When you call or file online, The Hartford will ask you to provide:

1. Name and other key identification information
2. Department and last day of active full-time work
3. Manager's name and phone number
4. Nature of claim and whether it's work-related
5. Treating physician's name, address and phone number

EMPLOYEE NAME (please print)

By signing below, I authorize my health care provider to release my medical files to The Hartford to assist with the review of my claim or application.

EMPLOYEE SIGNATURE

DATE