Pittsburgh Claim Service Center
P.O. Box 22328
Pittsburgh, PA 15222-0328
1-800-238-2125 Toll Free

Group/Association - Proof of Loss
Life Insurance
Accidental Death Insurance

CIGNA Group Insurance
Life • Accident • Disability

Connecticut General Life Insurance Company
Life Insurance Company of North America
CIGNA Life Insurance Company of New York

LMS-613500 (10/2005)

Clear Fields

FRAUD WARNING: Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act. ***For residents of the following states, please see last page: California, Colorado, District of Columbia, Florida, Kentucky, Maryland, Minnesota, New Jersey, New York, Oregon, Pennsylvania, Tennessee, Texas or Virginia.***

INSTRUCTIONS FOR FILING A CLAIM

THIS FORM IS FOR LIFE INSURANCE OR ACCIDENTAL DEATH PROCEEDS ONLY.
COMPLETE THE FORM ACCORDING TO THE INSTRUCTIONS, TO AVOID DELAY OR RETURN OF THE FORM.
To The Employer/Administrator: A. Submit completed form to your assigned Claim Office with a certified Death Certificate and Beneficiary Designation.
B. If there is no designated Beneficiary, a Preference Beneficiary's Affidavit must be completed and notarized.

SECTION TO BE COMPLETED BY THE EMPLOYER / ADMINISTRATOR

Name of Employee/Insured *(Last Name)* *(First Name)* *(Middle Initial)* | Date of Birth | Social Security No. | Sex ☐ M ☐ F

Address *(Street)* *(City)* *(State)* *(Zip Code)*

Insured's Marital Status
☐ Single ☐ Married ☐ Widow/Widower ☐ Separated ☐ Divorced

Policy Number(s) | Occupation | Was insurance issued on the basis of a statement of physical condition? *(If yes, attach copy)* ☐ Yes ☐ No

Please check the appropriate blocks regarding the insured's employment status.
Hrs./Wk. _____
☐ Active ☐ Exempt ☐ Management ☐ Supervisory ☐ Union Local #_____ ☐ Salaried ☐ Full-time
☐ Retired ☐ Non-Exempt ☐ Non-Management ☐ Non-Supervisory ☐ Non-Union ☐ Hourly ☐ Part-time

Basic Annual Earnings | Date of Last Change in Earnings | Date of Last Increase in Benefits | Amount of Insurance Basic: Supp: AD&D:

Date Hired/Member of Assoc. | Effective Date of Insurance | Date Last Worked | Date of Death | Premium Paid Through Date

Percentage of Insured's Contribution Toward Premium | Insured's Contributions Were Made on ☐ Pre-tax or ☐ Post-tax Basis | Has an assignment been taken? (If so please attach.) ☐ Yes ☐ No

Was the above Considered an Employee/Association Member until the Date of Death? If Not, Please Explain

If the employee was not actively at work immediately prior to death, what was the reason?
☐ Disability ☐ Leave of Absence ☐ Vacation ☐ Discharge
☐ Resigned ☐ Retired ☐ Temporary Layoff ☐ Other: _____

Was Coverage Still in Effect Through the Date of Death? If Not, Please Explain

EMPLOYER'S/ADMINISTRATOR'S CERTIFICATION

Name of Employer/Association | Division

Address *(Street)* *City* *(State)* *(Zip)* | Telephone Number

This is to certify that the facts as indicated on this form are true to the best of my knowledge and belief.

Signature | Title | Date

TO BE COMPLETED IF CLAIM IS FOR DEPENDENT BENEFITS

Name of Dependent *(Last Name)* *(First Name)* *(Middle Initial)* | Date of Birth | Social Security No. | Sex ☐ M ☐ F

Relationship to Employee/Association Member | Amount of Dependent Insurance | Dependent's Occupation

Is Child ☐ Full-time student ☐ Part-time student | Name & Address of School *(Street)* *(City)* *(State)* *(Zip Code)*

Was the Dependent Totally Disabled? ☐ Yes ☐ No | If yes, Date Disability Began

TO BE COMPLETED IF CLAIM IS FOR ACCIDENTAL DEATH BENEFITS

Where and How Did the Accident Happen? Please Describe in Detail	Date and Time of Accident

SECTION TO BE COMPLETED BY THE BENEFICIARY

Name of Beneficiary *(Last Name)* *(First Name)* *(Middle Initial)*	Date of Birth	Social Security No.	Sex ☐ M ☐ F

Address *(Street)* *(City)* *(State)* *(Zip Code)*	Relationship to Deceased	Daytime Telephone No.

Name and Address of Legal Guardian if Beneficiary is A Minor

Did the Deceased Have Other Insurance Coverage? ☐ Yes ☐ No	Type of Insurance	Policy Number(s)

Identify Insurance Carrier(s)

During the past 3 years, did the deceased use any form of tobacco product?

☐ Yes ☐ No

Please List Any Hospital, Clinics or Physicians That Treated the Deceased During the Past 5 Years.

Name	Complete Address	Treatment Period

I certify that the foregoing information is true, correct and complete to the best of my knowledge.

Beneficiary Signature _____ Date _____

CIGNAssurance® Program

If your insurance benefit is $5,000 or more, CIGNA will automatically open a free, interest-bearing account in your name. This account, called the CIGNAssurance® Program, is a safe, secure place to keep your proceeds while you decide how to best use them. A supply of personalized drafts will be mailed to you, once your claim has been approved. You can take all or part of the money out of the account simply by writing a draft. You may write an unlimited number of drafts, in any amount, at any time. Any amount that remains in the account will continue to earn interest at competitive rates. Both your principal and any interest you earn are guaranteed by the insurance company. You will receive a monthly statement for your CIGNAssurance® account, which will detail your account balance, interest earned, drafts cleared, and current interest rate. Drafts are cleared through a draft account at State Street Bank. This account is not insured by the Federal Deposit Insurance Corporation or any federal agency. Account balances are the liability of the insurance company and the insurance company reserves the right to reduce account balances for any payment made in error. If your life insurance benefit is less than $5,000, CIGNA will send you a check for the total benefit amount.

I understand that if my benefit is at least $5,000, I will receive a CIGNAssurance® Account. If I wish to receive my proceeds as a lump sum payment, I may simply write a draft for the total amount of the account.

Signature* _____ Date _____

*Please sign as you would sign on a check, as signature may be used for draft verification.

The insurance company, by providing a blank claim form, has not made a decision that there is coverage provided. All claims will be reviewed upon submission and the insurance company reserves all of its rights.

DISCLOSURE AUTHORIZATION (D)

Deceased's Name *(Please Print)*: _____ Deceased's Social Security #: _____

I AUTHORIZE: any doctor, physician, healer, health care practitioner, hospital, clinic, other medical facility, professional, or provider of health care, medically related facility or association, medical examiner, pharmacy, employee assistance plan, insurance company, health maintenance organization or similar entity to provide access to or to give the company named below (Company) or the Plan Administrator or their employees and authorized agents or authorized representatives, any medical and nonmedical information or records that they may have concerning my health condition, or health history, or regarding any advice, care or treatment provided to me. This information and/or records may include, but is not limited to: cause, treatment, diagnoses, prognoses, consultations, examinations, tests, prescriptions, or advice regarding my physical or mental condition, or other information concerning me. This may also include, but is not limited to, information concerning: mental illness, psychiatric, drug or alcohol use and any disability, and also HIV related testing, infection, illness, and AIDS (Acquired Immune Deficiency Syndrome), as well as communicable diseases and genetic testing. This information may also be extracted for use in audits or for statistical purposes.

I AUTHORIZE: any financial institution, accountant, tax preparer, insurance company or reinsurer, consumer reporting agency, insurance support organization, Deceased's agent, employer, group policyholder, business associate, benefit plan administrator, family members, friends, neighbors or associates, governmental agency including the Social Security Administration or any other organization or person having knowledge of me to give the Company or the Plan Administrator or their employees and authorized agents, or authorized representatives, any information or records that they have concerning me, my occupation, my activities, employee/employment records, earnings or finances, applications for insurance coverage, prior claim files and claim history, work history and work related activities.

I UNDERSTAND: the information obtained will be included as part of the proof of claim and will be used to determine eligibility for claim benefits, any amounts payable, return to employment opportunities, and to administer any other feature described in the plan with respect to the Deceased. This authorization shall remain valid and apply to all records, information and events that occur over the duration of the claim, but not to exceed one year from the date signed by the beneficiary or authorized representative. A photocopy of this form is as valid as the original and I or my authorized representative may request one. I or my representative may revoke this authorization at any time as it applies to future disclosures by writing the Company. The information obtained will not be disclosed to anyone EXCEPT: a) reinsuring companies; b) the Medical Information Bureau, Inc., which operates Health Claim Index (HCI); c) fraud or overinsurance detection bureaus; d) anyone performing business, medical or legal functions with respect to the claim or the plan, including any entity providing assistance to the Company under its Social Security Assistance Program and employers involved in return to employment discussions; e) for audit or statistical purposes; f) as may be required or permitted by law; g) as I may further authorize. A valid authorization or court order for information does not waive other privacy rights.

If my medical information contains information regarding drug or alcohol abuse, I understand that my records may be protected under federal (42 CFR Part 2) and some state laws. To the extent permitted under law, I can ask the party that disclosed information to the Company to permit me to inspect and copy the information it disclosed. I understand that I can refuse to sign this disclosure authorization; however, if I do so, Company may deny my claim for benefits pursuant to the plan. The use and further disclosure of information disclosed hereunder may not be subject to the Health Insurance Portability and Accountability Act (HIPAA).

Signature of Beneficiary or
Authorized Representative: _____ Date: _____

Relationship: _____

Company Name: _____

PROHIBITION ON RE-DISCLOSURE

If the medical information contains information regarding drug or alcohol abuse, it may be protected under federal law. Federal regulations (42 CFR Part 2) prohibit any person or entity who receives such protected information from the Company from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulation. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of such protected information to criminally investigate or prosecute any alcohol or drug abuse patient.

IMPORTANT CLAIM NOTICE

California Residents: Any person who knowingly presents a 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.

Colorado Residents: 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 settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

District of Columbia Residents: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida Residents: 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.

Kentucky Residents: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

Maryland Residents: Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any fact material thereto, may be committing a fraudulent insurance act.

Minnesota Residents: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New York Residents: 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 $5000 and the stated value of the claim for each such violation.

Oregon Residents: Any person who knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or, (2) conceals for the purpose of misleading, information concerning any material fact, may have committed a fraudulent insurance act.

Pennsylvania Residents: 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 subjects such person to criminal and civil penalties.

Tennessee Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Texas Residents: Any person who knowingly presents a 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.

Virginia Residents: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits application or files a claim containing a false or deceptive statement may have violated state law.