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



Connecticut General Life Insurance Company Life Insurance Company of North America CIGNA Life Insurance Company of New York Great-West Healthcare Administered by CIGNA 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 the last page of this form: California, Colorado, District of Columbia, Florida, Kentucky, Maryland, Minnesota, New Jersey, New York, Oregon, Pennsylvania, Rhode Island, 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 claiming voluntary or employee-paid benefits, include enrollment information for the current year and the previous two years (if available).

SECTION TO BE COM	PLETED BY THE	FMPI OYF	R/ADM	INISTRATOR E	OR FI	MPI OYF	AND D	<b>FPFNDFNT</b>	BENEFI	TS
Name of Employee/Insured (	Last Name) (	First Name)	(IVI	iddle Initial)	Date of	ΙΒΙπη	Social S	ecurity No.	Sex	
									□ №	1 □ F
Address (Street)			(City	<i>(</i> )			(State)	(Zip (	Code)	
, ,			` `	,			,	` '	,	
Insured's Marital Status	_	_		_	_				_	
☐ Single ☐ Married	☐ Widow/Widow	er 🛭 Sepa	rated	□ Divorced		omestic Pa	artner Rela	ationship	☐ Civil	Union
Policy Number(s)	Occupation Was insura					insurance	nce issued on the basis of a statement of			
, ,		·			phys	ical condition	on? (If yes	s, attach copy)	П V	□ N-
		/h.4		./ 1 1: /						⊔ NO
Check all of the boxes that app			-						/Wk	
☐ Active ☐ Exempt	☐ Management	☐ Supe							ull-time	
☐ Retired ☐ Non-Exempt	□ Non-Managem	ent 🗆 Non-	Supervi	sory 🛭 Non-U	nion		☐ Hou	ırly 🗆 P	art-time	
Basic Annual Earnings		Effective Date	e of Ear	nings		Emplo	vee's Divi	sion/Location		
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A manufact languages										
Amount of Insurance	0			ADAD (DI			· AD	D D ('(-)		
Basic:	Supp:			AD&D (Please of	complete	e only if cla	iming AD	&D Benefits):		
Date Hired/Member of Assoc.	Effective Date of	nsurance Dat	te Last \	Worked	Da	te of Death	)	Premium Pa	aid Throug	h Date
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	·		" -							
Percentage of Insured's Contrib		-		Contributions Were		-		ignment been		_
Basic: % Vo	oluntary:	_ % □	Pre-tax	or Post-tax B	Basis	(1	it so pleas	e attach.)       [	∃ Yes [	□ No
Was the above Considered an	Employee/Associat	ion Member u	ntil his/h	er Date		Was the a	above activ	vely at work ur	til the dat	e of the
of Death? ☐ Yes ☐ No If N							nt's death?			
						'		son below.	LI NO	
If the Company of a stime			/	ath an Danandanti						
If the Employee was not active										
1 —	_eave of Absence	□ FMLA		Temporary Layo		Resigned		ner:		
	id Leave of Absenc		on ⊔	Sabbatical		Discharge				
Was coverage still in effect thro	ugh the Date of De	ath?		Is there a	Benefic	iary Desigi	nation on f	ile for this Em	oloyee/Me	ember?
If Not, Please Explain				ПУ	s 🗆 N	JO.				
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				Please pro	ovide the	e most rece	ent benetic	ciary designati	on with th	e claim.
	TO DE COM	DI ETED IE		MIO EOD DE	DENID	ENT DE	NEELTO			
				M IS FOR DE						
Name of Dependent (	(Last Name) (	First Name)	(M	iddle Initial)	Date o	f Birth	Social S	ecurity No.	Sex	
										M $\square$ F
Relationship to Employee/Asso	ciation Member	Amount of	Denend	dent Insurance	1		Depend	ent's Occupati	on .	
Trelationship to Employee/Asso	ciation wember	I					Ворона	crit's Occupati	OII	
		Basic:		Voluntary:						
Was the Dependent Totally Dis	abled?	If yes, Dat	e Disab	ility Began			Depend	ent's Last Day	Worked	
☐ Yes ☐ No										
Dependent's Employer				Danandant's Em			1	lo Child		
Dependent's Employer				Dependent's Em	ipioyei s	5		ls Child ☐ F		
				Telephone Num	bei			□ P	art-time s	tudent
Name & Address of School	(Street)	(City	<i>'</i> )	(State)	(Zip	Code)		School Teleph	one Num	ber
	EMPL	YER'S/AD	MINIS	TRATOR'S C	ERTI	FICATIO	N			
Name of Employer/Assessing	LIVIPLO	JILK SIAD		TRAIDNS		ICATIO	Email A	ddrooo		
Name of Employer/Association							Email A	uuress		
Address (Stre	et)	City		(State)	(Zi	p)	Telepho	ne Number		
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This is to certify that the facts a	e indicated on this	form are true to	o the he	et of my knowled	ao ond i	holiof				
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Signature			Title				Date			

LMS-613500 Rev. 11/2010 Page 2 of 5

Where and How Did the Acc	ident Happ	oen? Plea	ase Describe	e in Detail	S FOR ACCID				Date and Time of Accident
		SECTIO	ON TO BE	E COME	LETED BY T	HE BENEFICIAR	Y		
Name of Beneficiary	(Last Na		(First Name		Middle Initial)	Date of Birth		Security No.	. Sex
Name of Beneficiary	(Last Iva	iiie)	(Filst Ivallie	<i>5)</i> (1	viidale Iriiliai)	Date of Bitti	Oociai C	county 140.	.   GCX
Address (Street)		(City)		(State)	(Zip Code)	Relationship to Dec		Doutimo	Telephone No.
Address (Sileet)		(City)		(State)	(Zip Code)	Relationship to Dec	easeu	Daytille	relephone No.
Face 3 Address									
Email Address									
Name and Address of Legal	Guardian i	if Beneficia	ary is A Mino	or					
Did the Deceased Have Oth	er	Type of In	nsurance			Policy Number(s)			
Insurance Coverage? ☐ Yes	s □ No								
Identify Insurance Carrier(s)									
During the past 3 years, did	the deceas	sed use an	y form of tol	bacco pro	duct?				
☐ Yes ☐ No									
Please List Any Hospital, Cli	nics or Phy	sicians Th				ast 5 Years.			
Name			Con	nplete Add	dress	Treatme	nt Period		
1 44 41 441 6			. ,						
I certify that the foreg	going in	rormatio	on is true	, correc	t and comple	te to the best of	ту кпо	wieage.	
- C - C									
Beneficiary Signature							D	ate	
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	ofit is \$F	5 000 or			ırance <sup>®</sup> Pro	•	iterest-h	earing a	count in your
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## Disclosure Authorization

CIGNA Group Insurance Life • Accident • Disability

Life Insurance Company of North America Connecticut General Life Insurance Company CIGNA Life Insurance Company of New York Great-West Healthcare Administered by CIGNA



Deceased's Name:

Deceased's Date of Birth:

**NOTE:** This authorization is designed to comply with HIPAA and relates to information necessary to administer coverage and services under your employer's employee health and welfare plan(s) ("the Plan") and similar or coordinating governmental benefits. You are not required to sign the authorization, but if you do not, the Plan, insurers or other providers of services or coverage under the Plan may not be able to process your request for Plan benefits, coverage or services.

#### **AUTHORIZATION**

I authorize any physician, medical professional or other health care provider, hospital or other medical facility; pharmacy; health plan; rehabilitation professional; vocational evaluator; employee assistance plan; insurance company, reinsurer, health maintenance organization, third party administrator, broker or other insurance service provider, or similar entity; the Medical Information Bureau; the Association of Life Insurance Companies, which operates the Health Claims Index and the Disability Income Record System; government organization or agency, including the Social Security Administration; financial institution, accountant or tax preparer; consumer reporting agency; and employer or group policyholder that has information about my health, financial, earnings or employment history, or other insurance claims and benefits to provide access to or copies of this information to the Plan and to any individual or entity who provides services to or insurance benefits on behalf of the Plan, including but not limited to the requesting company(ies) named below ("Company"). To the extent I may be eligible for governmental benefits similar to or that coordinate with those available to me under the Plan, I also authorize disclosure of information necessary to apply for or determine my eligibility for such benefits to the relevant government agency and/or vendor providing application assistance.

Information about my health may relate to any disorder of the immune system including but not limited to HIV and AIDS; use of drugs or alcohol; and mental and physical history, condition, advice or treatment, but does not include psychotherapy notes.

I understand that any information obtained with this authorization will be used for evaluating and administering my coverage, including any claim for benefits, or otherwise providing services related to or on behalf of the Plan, which may include, but is not limited to assisting me in returning to work and Plan administration. With respect to governmental benefits similar to or that coordinate with benefits available to me under the Plan, I understand that the information will be used to help determine my eligibility for any such benefits and may include assisting me in applying for the benefits. I understand that the information disclosed under this authorization is subject to redisclosure and may no longer be protected by certain federal regulations governing the privacy of health information, although it will continue to be protected by other applicable privacy laws and regulations.

For any claim for insurance benefits, this authorization is valid for the shorter of 24 months or the duration of my claim. For all other permitted disclosures, this authorization is valid for one (1) year from the date below. I am entitled to a copy of this authorization and a photographic or electronic copy of it is as valid as the original.

I understand that I do not have to give this authorization. If I choose not to give the authorization - or if I later revoke - I understand that the Plan, insurers, or other providers of services or benefits related to the Plan who rely on this authorization may not be able to evaluate or administer my request for Plan benefits, coverage or services and that my request for Plan benefits, coverage or services may be denied as a result. I may revoke this authorization by sending written notice to the Claim Manager handling my claim.

(Claimantha Cimpatura)	(Data Circal)
(Claimant's Signature)	(Date Signed)
(Print Name)	(Date of Birth)
I signed on behalf of the claimant as	(indicate relationship). If Power of Attorney Designee, document granting authority.

Company Names: Life Insurance Company of North America, CIGNA Life Insurance Company of New York, CIGNA Worldwide Insurance Company, Great-West Life & Annuity Insurance Company, First Great-West Life & Annuity Insurance Company, New England Life Insurance Company, Alta Health & Life Insurance Company and Connecticut General Life Insurance Company.

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### 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 willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

*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.

**Rhode Island Residents:** 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.

**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.

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